NEW PATIENT INTAKE FORM
GASTON MIKE LIU LLC

PATIENT NAME:_____ DOB:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

CELL PHONE #: _____ HOME PHONE #: _____

EMAIL ADDRESS:_____ SEX: MALE / FEMALE / OTHER

EMERGENCY CONTACT (*name, relation*):_____ TEL. #:_____

PHARMACY: _____ PHARM TEL. #:_____

PRIMARY CARE PHYSICIAN:_____

INSURANCE 1:_____ ID#:_____

Are you the PRIMARY SUBSCRIBER? YES / NO *(If No, please input name and relationship below)*

Name of PRIMARY SUBSCRIBER: _____ Relationship: SPOUSE / PARENT

INSURANCE 2:_____ ID#:_____

Are you the PRIMARY SUBSCRIBER? YES / NO *(If No, please input name and relationship below)*

Name of PRIMARY SUBSCRIBER: _____ Relationship: SPOUSE / PARENT

HOW DID YOU HEAR ABOUT US? _____

REASON FOR VISIT:_____ Date Last Seen By a Podiatrist? _____

ALLERGIES:_____ SMOKING: CURRENT / FORMER / NEVER

CURRENT MEDICATIONS (*Use the back of this form if additional space is needed):*

Name:_____ Name: _____

Name:_____ Name: _____

Name:_____ Name: _____

MEDICAL HISTORY: DIABETES / HEART DIS. / HYPERTENSION / BREATHING ISSUES / LIVER DIS. / KIDNEY DIS. / ARTHRITIS / CANCER / NEUROPATHY / OTHER:_____

SURGICAL HISTORY (*10 years*):_____

PLEASE READ AND SIGN:
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. (*Release of information*): I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Practice Notice. *(Medication History):* I authorize the Doctor's office to retrieve my medication history.

Patient Signature:_____ Date:_____