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Date \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
Last First (Mr. Mrs. Ms.)

RESIDENCE ADDRESS \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENT OR RESPONSIBLE PARTY EMPLOYED BY \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

NAME OF HUSBAND, WIFE, PARENT, OR NEAREST RELATIVE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HAVE YOU HAD PREVIOUS PROFESSIONAL FOOT CARE? \_\_\_\_\_ BY WHOM \_\_\_\_\_ WHEN \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

Name

Address

FAMILY PHYSICIAN \_\_\_\_\_

### **INSURANCE**

INSURANCE COMPANY \_\_\_\_\_ SUBSCRIBER NAME \_\_\_\_\_

SUBSCRIBER NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_ MEDICAID STATE ID NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ OTHER INSURANCE INFORMATION \_\_\_\_\_

**A WORD ABOUT INSURANCE:** Insurance coverage is a contract between you and the insurance company. The doctor does not determine the amount to be paid. The fees or any remaining balance due after the payment of primary insurance benefits is your responsibility.

**RELEASE:** I give the doctor permission to release information for Insurance Processing of my claim and to release information to my physician and associated medical personnel.

PATIENT'S SIGNATURE \_\_\_\_\_

## MEDICAL HISTORY

**Directions:** Please circle Yes or No to each question. Answer all questions and fill in black spaces when indicated.

Are you in good health . . . . . Yes No      Do you have any blood disorder such as anemia . . . Yes No

Has there been any change in your general health within the past year? . . . . . Yes No      Have you had surgery or x-ray treatment for tumor, growth or other condition of your feet . . . . . Yes No

My last physical examination was on \_\_\_\_\_      Are you taking any drug or medicine . . . . . Yes No  
If so, what \_\_\_\_\_

Are you now under the care of a physician . . . . . Yes No      Are you taking any of the following:      Yes No  
If so, what is the condition being treated \_\_\_\_\_      Antibiotics or sulfa drugs . . . . . Yes No  
Anticoagulants (blood thinners) . . . . . Yes No  
Medicine for high blood pressure . . . . . Yes No  
Cortisone (steroids) . . . . . Yes No  
Tranquilizers . . . . . Yes No  
Aspirin . . . . . Yes No  
Insulin, tolbutamids (orinase) or similar drug . . . . . Yes No  
Digitalis or drugs for heart trouble . . . . . Yes No  
Nitroglycerin . . . . . Yes No  
Other \_\_\_\_\_

Name and address of my physician is  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any serious illness or operation . . . . . Yes No      Are you allergic or have you reacted adversely to:  
If so, what was the illness/operation \_\_\_\_\_      Local anesthetics . . . . . Yes No  
Penicillin or other antibiotics . . . . . Yes No  
Sulfa drugs . . . . . Yes No  
Barbiturates, sedatives or sleeping pills . . . . . Yes No  
Aspirin . . . . . Yes No  
Iodine . . . . . Yes No  
Other . . . . . Yes No

Have you been hospitalized or had a serious illness within the Past (5) years . . . . . Yes No      Have you had any serious trouble associated with any previous podiatric treatment      Yes No  
If so, what was the problem \_\_\_\_\_      If so, explain \_\_\_\_\_

Do you have or have you had any of the following diseases Or problems?      Have you had any serious trouble associated with any previous podiatric treatment      Yes No  
Rheumatic fever or rheumatic heart disease . . . . . Yes No      If so, explain \_\_\_\_\_

Congenital heart lesions . . . . . Yes No      Do you have any disease, condition or problem not listed above . . . . . Yes No  
Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No      If so, please explain \_\_\_\_\_

Do you have pain in chest upon exertion . . . . . Yes No

Are you ever short of breath after mild exercise . . . . . Yes No

Do your ankles swell . . . . . Yes No

Do you get short of breath when you lie down or do you require extra pillows when you sleep . . . . . Yes No

Allergy . . . . . Yes No

Asthma or hay fever . . . . . Yes No

Hives or a skin rash . . . . . Yes No

Fainting spells or seizures . . . . . Yes No

Diabetes . . . . . Yes No

Do you have to urinate (pass water) more than six times a day . . . . . Yes No

Are you thirsty much of the time . . . . . Yes No

Does your mouth frequently become dry . . . . . Yes No

Hepatitis, jaundice or liver disease . . . . . Yes No

Arthritis . . . . . Yes No

Inflammatory rheumatism (painful swollen joints) . . . . . Yes No

Stomach ulcers . . . . . Yes No

Kidney trouble . . . . . Yes No

Tuberculosis . . . . . Yes No

Have a persistent cough or cough up blood . . . . . Yes No

Low blood pressure . . . . . Yes No

Venereal disease . . . . . Yes No

Other . . . . . Yes No

Have you had abnormal bleeding associated with Previous surgery or trauma . . . . . Yes No

Do you bruise easily . . . . . Yes No

Have you ever required a blood transfusion . . . . . Yes No

If so, explain the circumstances \_\_\_\_\_

\_\_\_\_\_

Women: Are you pregnant . . . . . Yes No