Cambridge Podiatry Center 259 West 231st St. Bronx. NY 10463 (718) 548-3080 Dr. Donald Spector

Patient Information Date_____ __

Last Name_____MI_____First Name_____

Age_____Date of Birth_____Gender M / F SSN_____/_____/_____Marital Status_____

Street Address_____Apt_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Employer Name and Address_____Occupation_____

Primary Insurance Co._____Member ID#_____

Insured under the name of_____Insured SSN #_____

Secondary Insurance Co. _____Member ID#_____

Insured under the name of_____Insured SSN #_____

Family Doctor_____Date Last Seen_____Phone_____

How did you hear about us?_____

Medical and Podiatry Information

Foot Problem_____

It has troubled me for: _____weeks _____months _____years Have you been treated for this condition before? Y N

Have you ever been treated for the following: **(circle to indicate YES)**

Diabetes	High Blood Pressure	High Cholesterol	Heart Disease	Osteoporosis
Asthma	Stomach Ulcers	Kidney Disease	HIV	Seizure Disorders
Depression	Bleeding Problems	Rheumatic Fever	Hepatitis	Circulatory Problems
Epilepsy	Arthritis	Other (describe)_____		

Family History: Diabetes_____High Blood Pressure_____Cholesterol_____Arthritis_____
Do you? Smoke_____Drink Alcohol_____ Use Recreational Drugs_____
Allergies: Are you allergic to any of the following? **(circle to indicate YES)**
Penicillin Latex Novocain Aspirin Iodine Codeine Adhesive/Tape Sulfa Other_____

Surgical History: Procedure(s)/ Year_____ _____

_____ _____

List **all** prescribed and over the counter medications that you are currently taking:

_____ _____ _____

_____ _____ _____

I have answered the above questions to the best of my knowledge. I understand that I AM RESPONSIBLE for any services rendered NOT covered by my medical insurance.

_____ _____

Patient's Signature Date