



Welcome To Our Office

Please PRINT the following information:

Patient Information

Date: _____

Legal Name: _____ Male Female
(Last) Mr. Mrs. Ms. (First) (Middle)

Date of Birth: _____ Age _____ Social Security Number _____ - _____ - _____

Address: _____
(Street) (City) (State) (Zip)

Phone: (Home) _____ (Cell) _____

Employer _____ Work Phone _____

Child Single Married Divorced Referred By _____

Family Doctor: _____ Referring Doctor: _____

Person Responsible For Bill

Legal Name: _____ Male Female
(Last) Mr. Mrs. Ms. (First) (Middle)

Social Security Number _____ - _____ - _____ Relationship to Patient: _____

Address: _____
(Street) (City) (State) (Zip)

Phone: (Home) _____ (Cell) _____

Employer _____ Work Phone _____

Insurance Company Information

Primary (1st)

INSURANCE: _____ Policy Holder's Name: _____

Policy Holder's SS# _____ - _____ - _____ Policy Holder's DOB: _____

Secondary (2nd)

INSURANCE: _____ Policy Holder's Name: _____

Policy Holder's SS# _____ - _____ - _____ Policy Holder's DOB: _____

Is your visit today related to: Workers Comp YES NO • Auto Accident YES NO • Liability Case YES NO

PLEASE READ: I hereby authorize CHRISTOPHER MASON, D.P.M., P.A. to release to your company or its representatives, any information including the diagnosis and the records of any treatment/examination rendered to me during the period of such medical or surgical care.

I understand and agree that I am financially responsible for any and all yearly or other deductibles, coinsurance, and any other services, procedures, or devices rendered to me which may not be covered under current health insurance plan(s). I further agree that I will pay for these obligations in full upon receipt of statement unless prior financial agreement has been made.

I also authorize and request your company to pay directly to the above named doctor(s) the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment for services, by reason of such treatment of services rendered to:

Signature of Patient

Signature of Insured

Reason for your visit today? _____

ALLERGIES to Medications _____

List Medications You Take: _____

Any Over-The-Counter?: _____
Any Holistic: _____
Any Herbal?: _____

Height: _____ Weight: _____
Are you being treated by a physician? _____

PAST MEDICAL HISTORY

Have you ever had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Scarring Tendencies |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Pacemaker/Stents | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Arthritis | | |

Are You Taking Any Anti-coagulants/Blood Thinners? _____

Comments: _____

SURGICAL HISTORY	OPERATION	DATE	SURGEON
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Any Problems with Anesthesia? _____ Healing? _____

FAMILY HISTORY

- | | | |
|--|------------------------------------|---------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |

Are you pregnant? _____

SOCIAL HISTORY

Coffee Tea Alcohol Tobacco

Recreational/Occupational Activities: _____

