

NORTHPOINTE FOOT & ANKLE ASSOCIATES

Medicine and Surgery of the Foot & Ankle

Charles G. Kissel, D.P.M.
Michael S. Schey, D.P.M.

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WELCOME TO OUR OFFICE

NAME: _____ AGE: _____ SEX: MALE FEMALE

BIRTHDATE: _____ SOCIAL SECURITY NO.: _____

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

HOME PHONE () _____ WORK PHONE () _____

MARITAL STATUS SINGLE MARRIED WIDOW DIV. SEP.

E-MAIL ADDRESS: _____ EMERGENCY PHONE () _____

EMERGENCY CONTACT NAME & RELATIONSHIP: _____

EMPLOYER'S NAME: _____ PHONE: _____

EMPLOYER'S ADDRESS: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHICH DOCTOR ARE YOU SCHEDULED TO SEE? Frederick Grant Hoffman Kissel Schey

HAVE YOU HAD PREVIOUS FOOT CARE BY A SPECIALIST? YES NO

IF YES, BY WHOM? _____

ARE YOU TAKING ANY MEDICATION? YES NO

IF YES, PLEASE LIST THEM BY NAME: _____

DO YOU HAVE ANY ALLERGIES? YES NO

IF YES, PLEASE LIST THEM BY NAME: _____

IF FEMALE, ARE YOU PREGNANT? YES NO

ARE YOU DIABETIC? YES NO IF YES, TYPE I TYPE II

IF YES, WHAT IS THE NAME AND PHONE NUMBER OF THE DOCTOR WHO TREATS YOU FOR DIABETES?

PLEASE PRESENT YOUR INSURANCE AND IDENTIFICATION CARDS AT THE FRONT DESK SO COPIES CAN BE MADE FOR YOUR RECORDS
THANK YOU!

Patient's Signature (or Parent/Guardian if patient is a minor)

Date