DR. Alan E. Robbins, DPM

DATE ____________

PATIENT INFORMATION

NAME____ SSN__________________________

ADDRESS______________________________ CITY____________ STATE_____ ZIP_____

HOME PHONE__________________ CELLULAR PHONE________________

DOB___________ AGE_______ SEX______ HEIGHT_______ WEIGHT_____

MARTIAL STATUS S M W D
(please circle)

PLACE OF EMPLOYMENT ___________________________OCCUPATION________________

WORK PHONE____________________

EMERGENCY CONTACT PERSON

NAME_________________ PHONE______________ REALTIONSHIP___________________

INSURANCE INFORMATION

INSURANCE NAME___________________ ADDRESS________________________________

POLICY#_________________ GROUP#_________________ PHONE#___________________

RESPONSIBLE PARTY

NAME________________ DOB_________ SSN____________________

REFERRING PROVIDER INFORMATION

NAME________________________PHONE#_________________

REASON FOR VISIT____

ASSIGNMENT OF BENEFITS

I hereby assign to Alan E. Robbins, DPM, any insurance proceeds, insurance benefits and/or other sources of payment relate to the account for services and goods which Alan E. Robbins, DPM has provided me and/or at my request. The said insurance proceeds, insurance benefits and/or other sources of payment are payable directly to Dr. Alan E. Robbins, DPM. In the event that Alan E. Robbins, DPM does not receive the said insurance proceeds, insurance benefits and/or other sources of payment within reasonable period of time, I understand that I am obligated to pay any part of the said account not so paid by the said insurance proceeds, insurance benefits and/or other sources of payment.

SIGNATURE OF INSURED______________________________ DATE_______________

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

MEDICAL HISTORY (circle illnesses you have had)

Heart Disease	Kidney Disease	Depression
Liver Disease	Cancer	HIV/AIDS
Diabetes	High Blood Pressure	Hepatitis
Stroke	Thyroid Disease	Swelling
Lung Disease	Other (please list) ______________	
TB	____________________________	

PAST SURGERY (list surgeries you have had)

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FAMILY ILLNESS (immediate family only) please circle

Cancer

Heart Disease

Colon Polyps

MEDS

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HABITS (please give amounts of each)

coffee	smoking
tea	alcohol
soda	

ALLERGIES

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