DAVID K. WYSONG, DPM, PC

***PLEASE PRESENT YOUR INS. CARD, LICENSE OR I.D. CARD, MEDICATION LIST AND ALLERGY LIST TO OFFICE STAFF**

Patient Name_____Date of Birth_____M or F
Address_____Zip Code_____
Home Phone#_____Cell#_____Work#_____
Email Address_____Social Security #_____
Employer Name & Address_____
Occupation_____

Spouse Name_____Date of Birth_____
Spouse Social Security #_____
Spouse Employer_____Work #_____

Insurance Information

Primary Insurance	Secondary Insurance
Company_____	Company_____
Policy No./GroupNo._____	Policy No./Group No._____
Insured Name_____	Insured Name_____
Insured Address_____	Insured Address_____
Insured SSN_____	Insured SSN_____
Birth Date_____	Birth Date_____
Insured Employer_____	Insured Employer_____
Insured Relationship_____	Insured Relationship_____

Spouse, Parent, or Legal Guardian Information

Name_____Relationship to Patient_____
Home Phone#_____Cell#_____Work#_____

In Case of Emergency

Name of Friend or Relative **not living with you**_____
Relationship to Patient_____
Phone #_____Cell#_____

Please Read & Sign

I hereby authorize Dr. David K. Wysong to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical service rendered to myself or my dependents covered by insurance.
I acknowledge that I am responsible for all deductibles, co-pay, and non-covered services.

SIGNATURE_____DATE_____

Patient Name_____Date of Birth_____

Present Medical Conditions:_____
_____
_____

Injury History - please list all broken bones, sprains, etc.
_____
_____
_____

Do you have any pins, screws, plates or implants?_____
Do you have any joint replacements?_____
Do you have a heart pace maker?_____
Have you ever had a reaction to general anesthesia?_____

Family History (circle all that apply)

Diabetes	High Blood Pressure
Foot Disorder	Kidney Disease
Cancer	Liver Disease
Arthritis	Other (specify)
Blood Disorder	
Heart Disease	_____

Present Medications (please list all medications including all over the counter meds) ***if you have a list - please give to office staff.**
_____
_____
_____
_____

Allergies or Medications not tolerated - including topicals, adhesive tape, etc.
_____
_____
_____
_____

Family Doctor_____Date last seen_____
Endocrinologist_____Date last seen_____
Cardiologist_____Date last seen_____

**Pharmacy_____Pharmacy Location_____

Patient Name_____Date of Birth_____

Height_____Weight_____Shoe Size_____

Social History

Do you smoke? Y or N - (if yes, packs per day)_____

Do you drink alcohol? Y or N - (if yes, how often)_____

Do you take any recreational drugs? Y or N - (if yes, list types)_____

Do you participate in sports? Y or N - (if yes, list types_____

Physical History - circle all that apply

Aids	Difficulty breathing	Malaria	Polio
Alzheimer's	Diphtheria	Measles	Raynaud's
Anemia	Epilepsy	Mitro valve prolapse	Rheumatic fever
Aneurysm	Glaucoma	Mumps	Scarlet fever
Ankle swelling	Gout	Muscular weakness	Sleep Apnea
Arthritis	Headaches	Narcolepsy	Stomach ulcer
Asthma	Hepatitis	Neurological problems	Stroke
Blood clots	Heart Disease	Osteoporosis	Thyroid disorder
Blood disorder	High blood pressure	Palpations	Tuberculosis
Bleeding tendency	Kidney disease	Paralysis	Venereal disease
Cancer	Liver disease	Parkinson's	Chicken Pox
Low back pain	Peripheral vascular disease	Diabetes	Lupus

Other/additional information_____

_____

Physical History - circle all that apply

Eyes:	Cataracts	Macular Degeneration	Glaucoma	Glasses	Contacts
Head:	Concussion	Trauma			
Ears:	Ringing in ears	Dizziness	Hearing Aids	Hearing loss	Meniere's
Nose:	Sinus	Allergies			
Throat:	Strep Throat	Tonsillitis	Cancer		
Lungs:	Emphysema	Cancer	Shortness of Breath		
GI:	Ulcer	Crohn's	Intestinal problems	Gerd	IBS
Skin:	Non healing Sores	Eczema	Psoriasis		
Joints:	Rheumatoid	Degenerative	Joint Implants	Gout	
Muscles:	Fibromyalgia	Muscular Dystrophy	Multiple Sclerosis		

Are you pregnant? Y or N

Surgery History - please list all surgeries and any complications with anesthesia:

_____

_____

_____

_____