

Paoli and Center City Foot Care Center

Patient: _____

Date _____

(Full name)

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Date of Birth: _____ Age: _____

E-mail address (will not be shared in any way): _____

Sex: M F Occupation: _____ Cellular #: _____
(_____) _____

Employer: _____ Work Phone: (_____) _____

Business Address: _____

Spouse's Full Name: _____ Occupation: _____

Your Pharmacy: _____ Town: _____ Phone #: _____

Emergency Contact - Name: _____ Phone: (_____) _____



SS#: _____ Medicare #: _____

Primary Ins. Co.: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Soc. Sec. # of Insured: _____ D.O.B of Insured: ___/___/___ Relationship: _____

Secondary Ins. Co.: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Soc. Sec. # of Insured: _____ D.O.B of Insured: ___/___/___ Relationship: _____

Referred by: _____ Date of Last Physical : _____ By Whom: _____

Family M.D. _____ Address: _____



What is your foot problem(s): _____

Shoe Size: _____ Have you ever worn custom made arch supports (orthotics) Y N Do you smoke? Y N

Illnesses: (Check those which apply):

- Poor Circulation Heart Disease Liver Disease Diabetes Arthritis Anemia
- Kidney Problem Hepatitis Lung Problems Back Problems Bleeding Disorders
- Asthma Gout High Blood Pressure Rheumatic Fever Stroke Back Pain
- Neck Pain Numbness in Feet

Allergies to Medications: (Check those which apply):

- Penicillin Aspirin Codeine Adhesive Tape Iodine
- Sulpha Sea Food Local Anesthetic Other: _____

Medication Taking: (Prescription and non-prescription)

Prior Surgery or Illnesses:

I hereby give my permission to the doctors at Robert K. Cohen, DPM, PC to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ **DATE:** _____