MICHAEL J. TREPAL, D.P.M. & KEVIN T. JULES, D.P.M., P.C.

PODIATRIC MEDICINE AND FOOT SURGERY
300 CADMAN PLAZA WEST 17TH FLOOR, BROOKLYN HEIGHT NEW YORK 11201
TEL (718) 624-8022 FAX (718)624-7727

MICHAEL J. TREPAL, D.P.M., F.A.C.F.A.S.

KEVIN T. JULES, D.P.M., F.A.C.F.A.S.

DIPLOMATES, AMERICAN BOARD OF PODIATRIC SURGERY
FELLOWS, AMERICAN COLEGE OF FOOT AND ANKLE SURGEONS

WELCOME TO OUR OFFICE

We are pleased that you have chosen us to provide care for your foot problem and look forward to having you as our patient. The initial evaluation will encompass a complete history and evaluation of your complaint. We will then discuss your problem and the various treatment regimens. No matter how much time is spent on your examination, every effort will be made to relieve you of any discomfort on this initial visit. Please complete the following forms and answer each question so that we may provide you with the optimal care.

In order to minimize billing costs we request payment at the time of service, unless you are a member of an insurance plan with which this office participates in. Please provide our office staff with all insurance documentation for each plan you are covered under. Please do not hesitate to inquire about any fee or service related to your care.

Patient:

First Name _____ **Last Name** _____**Date of Birth**____/____/____ **Age**____

Address_____**Apt#**_____**City**_____**State**_____**Zip**_____

Home #_____**Cell #** _____**Email** _____

Sex: M F **Marital Status S M W D** **Social Security #** _____ -_____ - _____

Employer Name_____ **Occupation**_____

Employer Address_____ **City** _____**State** _____ **Zip** _____

Work #_____**Extension** _____

Emergency Contact _____**Phone #** _____**Relationship to patient**_____

Insurance Information:

Primary Insurance _____**ID#** _____**Group#:**_____

Name of Policy Holder _____**Date of Birth** ____/___/____ **Relationship to Patient** _____

Secondary Insurance _____ **ID#** _____ **Group #** _____

Name of Policy Holder _____**Date of Birth** ___/____/____ **Relationship to Patient**_____

Is This A Work Related Injury? Yes or No If yes, date of Accident _____/_____/____ Claim# _____

Adjustor _____ Phone#_____

Medical Information:

Primary Care Physician _____ Phone# _____

Address_____ City _____ State _____ Zip _____

Pharmacy Name _____ Phone# _____

Whom May We Thank For Referring You To This Office?

Doctor _____ Phone#_____

Friend/Patient_____

Please Answer All Questions

Please describe your foot problem(s) _____

How long has it bothered you? _____

Previous treatment of any foot problem_____

Previous Operations: _____

Have you been treated or suffer from any of the following?

ILLNESS	YES	NO	COMMENTS
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Asthma/ Breathing			
Kidney/Bladder			
Liver/Hepatitis			
Arthritis			
Ulcer/Digestive			
Poor Circulation			
Bleeding Disorder			
Blood Transfusion			
Neurologic Disorder			
Cancer			
Thyroid			
Sexually Transmitted Disease			
Substance Abuse			
Allergies			

Patient Name: _____ Signature: _____ Date: _____