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PLEASE HELP US KEEP OUR RECORDS UP TO DATE BY FILLING OUT THIS FORM AS ACCURATELY AS POSSIBLE. THANK YOU.

Date:_____

Name:_____ Date of Birth_____ Male/Female

Address:_____ City&State:_____

Zipcode:_____ Home Phone:_____ Cell Phone:_____

Occupation: _____Work Phone: _____

Email Address: _____

Primary Doctor: _____Phone:_____Last Visit:_____

Spouse/Closest Relative: _____Phone: _____

Person Responsible for Bills/Relationship: _____

Pharmacy Name, Location and Phone: _____

ASSISGNMENT OF BENEFITS:

I HEREBY ASSIGN PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND OTHER INSURANCE COMPANIES MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL, TO WHICH ENTITLED, TO BE MADE EITHER TO ME OR ON MY BEHALF, TO DR. ROBERT SOLOMON FOR SERVICES RENDERED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE SAID INFORMATION, REGARDING BENEFITS FOR PAYABLE RELATED SERVICES. A PHOTO COPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES APPLIED TO MY DEDUCTABLE. I HEARBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signature: _____ Date: _____

Refered by: _____

Medication/Supplements	Dosage	Frequency

1. Have you experienced any allergic reaction to, or any ill effects from cortisone, aspirin, red dye, iodine, adhesive tape, tranquillizers, wool, pain killers, narcotics. Novocain (or any other local anesthetic), penicillin, sulfa (or other antibiotics)? (UNDERLINE)

   Any other allergies? _____
2. Are you subject to prolonged bleeding? Yes/No
3. Do you have a personal history of diabetes? Yes/No
4. Is there a family history of diabetes? Yes/No
   If yes, relation?_____
5. Are you subject to any nervous disorders, fainting or dizziness? (UNDERLINE)
6. Have you had any of the following: heart murmur, asthma, epilepsy, rheumatic fever, anemia, kidney or liver involvement, lung disease, glaucoma, stomach or duodenal ulcers, phlebitis, cancer, gout, tuberculosis, venereal disease, high blood pressure, HIV, alcohol or drug abuse (or excess), neurologic disorders, skin cancer or arthritis? (UNDERLINE)
   Any other conditions? _____
7. When was you last tetanus booster? Date:_____
8. Do you smoke cigarettes? Yes/No
9. Have you had any major operations? Yes/No
   If yes, explain: _____
   _____
   *Have you experienced problems with anesthesia? Yes/No
10. Have you had any injuries to your feet, ankles, legs or back? Yes/No

    If yes, explain: _____
    _____
11. Are you currently under a doctor's care? Yes/No

    Whom?_____What Condition?_____
12. Chief Complaint: _____

Weight: _____Height: _____Shoe Size _____

SIGNATURE: _____DATE:_____