EVANSTON FOOT AND ANKLE CLINIC

DR. KEVIN J. TUNNAT

Physician and Surgeon of the Foot and Ankle

WELCOME TO OUR OFFICE

NAME ____________________ BIRTHDATE __________ AGE ________ SEX M or F

ADDRESS ____________________ # ________ CITY __________ STATE ________ ZIP ________

SS # ____________________ MARITAL STATUS S M W or D HOME TELEPHONE # ____________________

WIRELESS TELEPHONE # ____________________ E-MAIL ADDRESS ____________________

WEIGHT __________ SHOE SIZE __________ PARENT OR GUARDIAN, IF MINOR ____________________

OCCUPATION ____________________ ☐ EMPLOYED ☐ RETIRED ☐ HOMEMAKER ☐ STUDENT ☐ DISABLED ☐ NOT EMPLOYED

EMPLOYER ____________________ WORK TELEPHONE # ____________________

WORK ADDRESS ____________________ CITY __________ STATE ________ ZIP ________

HEALTH INSURANCE CO. ____________________ INSURED'S NAME (IF NOT PATIENT) ____________________
(PLEASE ATTACH YOUR INSURANCE CARD(S) TO BE PHOTOCOPIED)

IDENTIFICATION # ____________________ INSURED'S BIRTHDATE __________

REFERRED BY: ☐ DR. ☐ INS. CO. ☐ YELLOW PAGES ☐ INTERNET ☐ FAMILY MEMBER OR FRIEND'S NAME ____________________

FAMILY DOCTOR ____________________ LAST SEEN __________ FORMER PODIATRIST ____________________

PLEASE LIST ANY MEDICATION YOU ARE TAKING ____________________

____

ARE YOU ALLERGIC TO ANY MEDICATION? ____________________
(FOR EXAMPLE: PENICILLIN, SULFA, NOVOCAINE, IODINE, ADHESIVE TAPE, ASPIRIN, CODEINE, ETC.)

ARE YOU DIABETIC? Y or N HAVE YOU EVER HAD ANY SERIOUS ILLNESS? Y or N (IF YES, PLEASE SPECIFY) ____________________

____

DO YOU HAVE OR EVER HAD, ANY OF THE FOLLOWING: (CHECK IF YES)

☐ CANCER	☐ ANEMIA	☐ SEIZURES	☐ HYPERTENSION
☐ GOUT	☐ HEMOPHILIA	☐ HEPATITIS	☐ RHEUMATIC FEVER
☐ STROKE	☐ PACEMAKER	☐ BLOOD CLOTS	☐ LIVER DISEASE
☐ ASTHMA	☐ ANKLE EDEMA	☐ TUBERCULOSIS	☐ KIDNEY DISEASE
☐ GI ULCER	☐ PSYCHIATRIC CARE	☐ LEG CRAMPS	☐ BLEEDING DISORDER
☐ ANGINA	☐ RESPIRATORY DISORDER	☐ HEART DISEASE	☐ POOR CIRCULATION
☐ ARTHRITIS	☐ SHORTNESS OF BREATH	☐ HEART ATTACK	☐ NEUROLOGICAL DISORDER
☐ HIV/AIDS	☐ DIGESTIVE PROBLEMS	☐ CHEMICAL DEPENDENCY	☐ ARTIFICIAL HEART VALVES OR JOINTS

WHAT IS YOUR FOOT COMPLAINT? ____________________

PLEASE RANK YOUR WORST PAIN ON A SCALE OF 1 TO 10 (10 BEING EXCRUCIATING): ____________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I HEREBY AUTHORIZE MEDICAL TREATMENT AND PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES DESCRIBED HEREIN. I HEREBY CONSENT AND GIVE PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS HE DEEMS NECESSARY.

X SIGNATURE ____________________ DATE __________

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