WELCOME TO OUR OFFICE

RIVER FOREST FOOT CLINIC

Dr. Linda S. Lambert

Name_____________________________ Birth Date __________ Age______________
Parent/Guardian ______________________ Spouse______________________________
Street ________________________Apt #______City ______________ State ____Zip______
Marital Status ______________Email____
Home Phone ________________Cell Phone ________________SSN_________________

EMPLOYMENT INFO

Employer_______________________________________Phone______________________
Address____
Spouse's Employer _______________________________Phone______________________
Medical Insurance____
Secondary Insurance____

MEDICAL HISTORY

Date of Last Medical Exam ___________MD Name__________________________________
MD Phone ________________MD Fax _________________MD City ________________
List Medications ____
____
Allergies____
Surgeries____
____
Height _____ Weight ______Are you pregnant? _____Do you smoke? _____ Drink? _____

Please check if you have a history of:

Diabetes _______Asthma _______Anxiety _______Anemia _______Blood Clots_________
High Blood Pressure _______ Cancer _______Kidney Disease_______ Gout __________
Heart Disease_______ GI Ulcer _______ Liver Disease _______ Polio ___________
Stroke/TIA ________Arthritis _______Rheumatoid Arthritis _______Leg Cramps_________
Parkinson's _______ Alzheimer's ________MS _________Rheumatic Fever __________
Arterial Disease _______Varicose Veins _____HIV/AIDS _______Sciatica______________
Epilepsy ______ Lymphedema ______Other ______________________________________

FAMILY HISTORY: illness/cause of death

mother___________________**father**__________________**grandmother**________________
grandfather_________________**son**__________________ **daughter**___________________

How did you hear about our office? ____
Reason for your visit ____

ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Linda Lambert to release any information acquired in the course of my treatment necessary to process insurance claims. I assign any benefits payable by my insurance carriers(s) to Dr. Lambert for services rendered. I understand that I am responsible for any amount not covered by insurance.

_______________________________________ Date____________
Signature of Insured/Authorized Person