

WELCOME TO

The office of Dr. David Bowers, DPM
2604 W. Johnsburg Rd, Johnsburg, IL 60051
Phone: (815) 675-9090 Fax: (815) 207-7808

PATIENT INFORMATION

Name: _____ Date: _____

Spouse Name: _____

Name of Guardian if minor: _____ Relationship (Mom, Dad...) _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Birthdate: _____ Age: _____ Gender: _____ Marital Status: _____

List whom you authorize us to share your medical information with: _____

Home Phone (____) _____ Cell Phone(____) _____ Work Phone(____) _____

Occupation: _____

Employer: _____

Is this Workman's comp? () yes () no If yes, date of injury: _____

Primary Insurance Co. _____

Secondary Insurance Co. _____

Are you in () good health () Fair Health () Poor Health

Physician's Name & Phone #: _____

Do you smoke, how much: _____.

Alcohol use; Number of drinks per week: _____

Please **list your medications:** _____

List all medications you are allergic to? _____

Please **circle** if you had or have any of the following:

Diabetes	Aids (HIV	Leg Cramps	Tumors
Epilepsy	Asthma	Cancer	Anemia
Heart Problems	Varicose Veins	High BP	
Stomach Ulcers	Bursitis	Liver Problems	
Bleeding Tendencies	Glaucoma	Rheumatic fever	
Rheumatism/Arthritis	Kidney Problems	Migraine Headaches	

Other medical conditions: _____

Surgeries in the past 3 years? _____

What is your current foot/ankle problem? _____

Home treatment & results? _____

Previous Podiatrist: _____

How did you find our practice? _____

For Insurance Purposes - Please Sign

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or the party who accepts assignment. I understand that I am responsible for payment of all charges. As a courtesy, I understand my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature (Patient or Authorized Person)