WELCOME TO OUR OFFICE

NAME _____

DATE OF BIRTH _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____

PRIMARY PHYSICIAN _____ LAST VISIT _____

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

PATIENT REFERRAL _____ (PERSON"S NAME)

PHONE BOOK _____ DR. REFERRAL _____ WEB SITE _____ OTHER _____

PREVIOUS FOOT CARE? _____

CHIEF FOOT PROBLEM _____

DO YOU HAVE ANY OF THE FOLLOWING(Check all that apply):

____ARTHRITIS	____HEPATITIS	____LIVER DISEASE
____ABNORMAL BLEEDING	____HIGH BLOOD PRESSURE	____STOMACH ULCER
____CANCER	____HIV/AIDS	____STROKE
____DIABETES	____GOUT	____POOR CIRCULATION
____HEART CONDITION	____KIDNEY DISEASE	____LOWER BACK PROBLEMS

OTHER _____

I HEREBY GIVE MY PERMISSION TO DR. GEORGE VASILIADIS TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.I ALSO AUTHORIZE PAYMENT OF ANY SUCH SERVICES TO BE MADE DIRECTLY TO THE AMBULATORY FOOT CARE CENTER.

DATE _____ SIGNATURE _____