# Dr. Michael E. Newman and Dr. Denise A. Kohler

**RACE** (Optional): White ___ AfrM/Amer/Black ___ Asian___ Native Hawaiian or Other Pacific Islander ___ American Indian___ Alaska Native ___

**ETHNICITY** (Optional): Hispanic or Latino ___ Not Hispanic or Latino ___

**INSURANCE INFORMATION:** Please present your card(s) to a staff member to copy your insurance and group numbers

**PRIMARY MEDICAL INSURANCE COMPANY** _____

**SECONDARY MEDICAL INSURANCE COMPANY** _____

**SUBSCRIBERS NAME** _____ **RELATIONSHIP TO PATIENT** _____

**SUBSCRIBERS DATE OF BIRTH** ____ /____ / ____ **EMPLOYER** _____

**PRIMARY CARE/FAMILY PHYSICIAN OR GROUP** _____

**MEDICATIONS**: PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING: ___ **NOT TAKING ANY MEDICATIONS**

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

**LIST ANY OTHERS** _____

**PHARMACY NAME AND PHONE** (If Known) _____

**ADDRESS** (If Known) _____

**FOR DIABETICS – LAST DR. VISIT** _____ **BLOOD SUGAR** _____ **A1c** _____ **LAST DATE** ___ /___ /____

**SOCIAL HISTORY** – DO YOU USE OR HAVE YOU USED ANY OF THE FOLLOWING:

**SMOKING HISTORY**:___NEVER ____ FORMER SMOKER ____CURRENT EVERYDAY SMOKER ____OCCASIONAL SMOKER

**ALCOHOL USE**: ____YES ____ NO ____ SOCIAL ____ MILD ____ MODERATE ____ HEAVY ____ QUIT

**LAST SEEN BY A PODIATRIST**: ____ / ____ / _____ **NEVER** ____ **FEMALES**: CURRENTLY PREGNANT ___YES ___NO

**HOW WERE YOU REFERRED TO OUR OFFICE:**

____Primary Care Physician/Family Physician ____Internet ____Web Site ____Existing Patient ____Church Bulletin ____Pediatrician

____Insurance or Hospital Referral Service ____Other Specialist ____Newspaper or other advertisement ____Phone Book

Other_____

I certify that the above information is correct.

**PATIENT SIGNATURE** _____ **DATE** _____ / _____/ _____