HOWARD L. WEINSTEIN D.P.M.
FOOT SPECIALIST AND SURGEON
TOTAL FAMILY FOOT CARE

cell# ____________________

WELCOME TO OUR OFFICE

PATIENT INFORMATION

PATIENT'S NAME ______________________________
First M.I. Last

HOME ADDRESS ______________________________
Street Number

____
City State Zip

HOME ______________ WORK ______________

BIRTHDATE ______________________________
Month Date Year Age

SOCIAL SECURITY # ______________________________

MARITAL STATUS: (please Circle appropriate status)

Single Married Widow Widower Separated Divorced

PLACE OF EMPLOYMENT ______________________________
Company Name

____
Location Occupation

Please complete this section if patient is under 18 years of age:

PARENTS NAME: ______________
(Responsible Party)

ADDRESS: ______________
(If different than patients) Street

____
City State Zip

HOME TELEPHONE # ______________

WORK TELEPHONE # ______________

BIRTH DATE ______________

SOC. SEC.# ______________

Place of Employment

____
Company Name

____
Location Occupation

EMERGENCY CONTACT: ______________________________
name & phone #

FAMILY PHYSICIAN ______________________________
Name Location Phone Number

REFERRED BY ______________________________
Name (Doctor, Friend, Etc.) Street Address City State Zip

OFFICE FEES AND INSURANCE BILLING:

The fee for your initial office visit and follow-up visits is payable at the time of service. Services such as diagnostic x-rays, injections, casting, etc., are additional and will be billed to your insurance, whenever possible.
I hereby give my permission to the above doctor to administer treatment, and to perform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

______________________________ ______________
SIGNATURE DATE