**Last Name**_____ **First Name**_____**M.I.**_____

**Address**_____

**City**_____ **State**_____ **Zip**_____

**Home Phone (  )**_____ **Cell Phone (  )**_____

**Birthdate**_____ **Age**_____ ***E-Mail**_____

**Social Security #**_____-_____-_____ **Male Female Married Single**

**Employer**_____ **Title**_____ **Phone**_____

**Spouse's Full Name**_____

**Emergency Contact**_____**Phone**_____

**Family Doctor**_____ **Last Visit**_____

**How Did You Hear About Dr. Long?**_____

**Allergies (Check All That Apply):**

_____ No Known Allergies _____ Adhesive Tape _____ Aspirin _____ Codeine
_____ Cortisone _____ Local Anesthetic _____ Latex _____ Penicillin
_____ Sulfa Other_____

**Have You Ever Been Treated For:**

_____ Arthritis _____ Abnormal Bleeding From A Cut _____ Anemia
_____ Diabetes _____ Asthma _____ Gout
_____ Heart Problems _____ High Blood Pressure _____ Kidneys
_____ Low Back Pain _____ Phlebitis _____ Stroke
_____ Ulcers Other_____

**Smoking: No Yes ____packs/day** **Alcohol: No Occasionally Daily**

**Chief Foot Complaint**_____

**Present Medical Problems** _____

_____

**Major Operations or Injuries** _____

_____

**List All Present Medications** _____

_____

_____

_____

OVER PLEASE

.

* E-mail addresses are used for contact information only and will not be shared with anyone

**Primary Insurance**_____ **Name of Policyholder**_____

**Policyholder's Social Security #**_____-_____-_____ **Policyholder's Date of Birth**_____

**Employer**_____ **Work Phone**_____

**Secondary Insurance**_____ **Name of Policyholder**_____

**Policyholder's Social Security #**_____-_____-_____ **Policyholder's Date of Birth**_____

**Employer**_____ **Work Phone**_____

**PLEASE READ CAREFULLY BEFORE SIGNING**

**As part of our office policy, we require that your deductible (if not met), co-payment, and/or co-insurance be paid in full at the time of treatment. You are fully responsible for any amount not paid by insurance. Our office accepts cash, check, Visa, Mastercard, and Discover.**

**I hereby authorize Dr. William S. Long /Upstate Podiatry Group, PA to release to my insurance company or other medical professionals any medical information acquired in the course of my examination or treatment. I also authorize payment from my insurance company to Dr. William S. Long/ Upstate Podiatry Group, PA for any surgical and/or medical benefits due for services rendered.**

******I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.**** _____ (please initial) ****Located in the waiting room next to the receptionist window in the magazine rack******

_____ _____

**Patient/Responsible Party** **Date**

**IF PATIENT IS UNDER 18 YEARS OLD OR A FULL TIME STUDENT,**
**PLEASE COMPLETE THE FOLLOWING INFORMATION:**

**Mother's Name**_____

**Employer**_____ **Work Phone**_____

**Father's Name**_____

**Employer**_____ **Work Phone**_____