Fred M. James, DPM/Matthew R. Hahne, DPM

Email your completed form(s) to lincolnfootclinic@gmail.com

Name: Last, First, M.I. _____ Are you the responsible party? Y / N

If no, who is? (parent, spouse, POA, etc): _____ Spouse Name _____

Address: _____

City, State, Zip: _____

Phone #s: Home ____-____-_____ Work ____-____-_____ Other ____-____-_____ Soc. Sec # ____-____-_____

Birth Date: ____ / ____ / _____ Sex: M F Shoe Size & Width _____ Height _____ Weight _____

Primary Insurance _____ Policy # _____ Eff. Date _____

If you are not the primary cardholder, ***we must have*** D.O.B. ____ / ____ / _____ SS# ____-____-_____ of cardholder

Secondary Insurance _____ Policy # _____ Eff. Date _____

Employer: _____

Physician: _____ Pharmacy: _____

Why are we seeing you today? _____

** If you (the patient) are seeing the doctor today because of an accident, please complete the questions below:

Date of Accident or Injury _____

Explain how and where the accident or injury occurred _____

_____

Is this visit work related? Y / N (If yes, have appropriate documentation)

Were You Referred To Our Office? _____ If Yes, By Whom? _____

List Current Medications (Include Non-Prescription, Eyedrops, Insulin, Inhalers, Herbal)

Name of Drug	Dosage	# of Times per Day