

~ WELCOME ~

LAWRENCE S. LEIBOWITZ, D.P.M.
PODIATRIC MEDICINE & SPORTS PODIATRY
BOARD CERTIFIED BY THE AMERICAN BOARD OF PODIATRIC MEDICINE

Cell number: _____

Last Name First Age SS# Date of Birth Marital Status

Address City State Zip Code Phone Number

Employer Phone Number

Insurance Co. _____ Policy # _____ Other Ins. _____

Referral Needed? Y___ N___

Name of Person Responsible for Payment _____ Relationship to Patient _____

How Did You Hear About Our Office? _____

Medical Doctor _____ Address _____ Phone # _____

Date Last Seen _____ Pharmacy _____ Phone Number _____

Please Check All Current and Past Medical Conditions:

Diabetes (sugar) _____	High Blood Pressure _____	Breathing Problems _____	Stomach Ulcers _____
Heart Disease _____	Chest Pain _____	Lung Disease _____	Blood Disease _____
Tuberculosis _____	Drug Abuse _____	Alcohol Abuse _____	Liver Disease _____
Kidney Disease _____	Seizures _____	Rheumatic Fever _____	Mental Health Disorder _____
Difficulty Healing When Cut _____		Neurologic Disorder _____	High Cholesterol _____
Thyroid Disorder _____	Smoker _____	Cancer _____	Venereal Disease _____
Arthritis _____	Vascular Disease _____	Other _____	

List All Medications You Are Presently Taking _____

Check if You Have Any Allergies to Any of the Following Medications:

Penicillin _____	Any Antibiotic _____	Sulfa _____	Anti-Inflammatories _____	Cortisone _____
Aspirin _____	Novocaine/Lidocaine _____	Pain Medications _____	Codeine _____	Other _____
Tape _____	Foods; list _____			

List Any Sports You Participate In _____

List Surgical Procedures & Dates _____

List Previous Foot Problems or Surgeries & Dates _____

Reason for Your Visit Today _____

I authorize Dr. Leibowitz to administer treatment, and/or perform such procedures as may be necessary; including local anesthesia, for the diagnosis and/or treatment of my foot/ankle:

Signature _____ Date _____ Relationship if a Minor _____