~ WELCOME ~

LAWRENCE S. LEIBOWITZ, D.P.M.
31 ROUTE 206, SUITE 1
AUGUSTA, NEW JERSEY 07822
PHONE (973) 383-5421/FAX (973) 579-0015

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) ____
Heart Disease ____
Tuberculosis ____
Kidney Disease ____
Difficulty Healing When Cut ___
Thyroid Disorder ____
Arthritis ____

High Blood Pressure ____
Chest Pain ____
Drug Abuse ____
Seizures ____
Smoker ____
Vascular Disease ____

Breathing Problems ____
Lung Disease ____
Alcohol Abuse ____
Rheumatic Fever ____
Neurologic Disorder ____
Cancer ____
Other _____

Stomach Ulcers ____
Blood Disease ____
Liver Disease ____
Mental Health Disorder ____
High Cholesterol ____
Venereal Disease____

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 ____ Novicaine/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 _____