

Drs Raymond & Laura Soluri
185 Merritts Rd, Farmingdale, NY 11735 www.FootDrs.com

Welcome to Our Office

First name: _____ Last name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Cell phone: _____ Work phone: _____ ext: _____

Marital status: () Married () Single () Divorced () Widowed Sex: () Male () Female

Social Security # _____ Date of birth _____

Family physician _____ City _____ Phone _____

How did you hear about our office? _____

Primary insurance _____ Policy # _____

Name of insured _____ Sex: () Male () Female Date of birth: _____

Relationship of patient to insured: () Self () Spouse () Child

Secondary insurance _____ Policy # _____

Main foot complaint that brought you to our office: _____

MEDICAL HISTORY: Do you have or have you had any of the following medical conditions:

___ Diabetes, ___ Arthritis, ___ Heart Trouble, ___ High Blood Pressure, ___ Stomach Ulcers,
___ Poor Circulation, ___ Asthma, ___ Cancer, ___ Anxiety, ___ Depression, ___ Kidney Disease
___ Phlebitis, ___ Gout

Other: _____

Family history of diseases (Diabetes etc.): _____

Past major surgeries: _____

Current medications: _____

Allergies: () Penicillin () Sulfa drugs, Other: _____

Social history:

Smoke () No () Yes _____ Packs/day for _____ years. Quit _____

I hereby give my permission to Dr. Raymond Soluri or Dr. Laura Soluri to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party _____ Date _____