Robert Lim, DPM
National Athletic Ankle & Foot Institute

PATIENT INFORMATION (Please Print)

Name__________________________ Address__________________________

City_____________________State_____Zip___________Male___ Female___

Birth Date____________ Age_____ Social Security #___________________

Home Phone (_____)_____________Cell Phone (_____)________________

Work___________________________ Address__________________________

City_____________________State_____Zip___________

Work Phone (_____)______________ Email___________________________

Marital Status_____________________ Shoe size___________

In Case of Emergency, Contact_____________________________________

Phone (_____)________________ Relationship__________________________

How did you hear about our office?___________________________________

INSURANCE INFORMATION

Primary Insurance Co.____

Name of Insured__________________________Date of Birth______________

ID#_________________________________Group #_______________________

Secondary Insurance Co.____

Name of Insured__________________________Date of Birth______________

ID#_________________________________Group #_______________________

HEALTH HISTORY

Foot/Ankle Complaint(s)____

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How long have you had the problem(s)?______________________________

Medical History, Please check if you have or had any of the following conditions:

___Diabetes
___High Blood Pressure
___Kidney Condition
___Asthma/Lung Condition
___Leg Cramps
___Gout
___Blood Clots
___Tuberculosis
___Arthritis
___Circulation/Bleeding Problems
___Heart Condition
___Liver Condition
___Cancer (Location____________________)
___Stomach/Intestinal Condition
___Artificial Joints or Valves
___Muscle Disease (MS, Polio)
___Blood Disease (Anemia, Sickle Cell)
___Epilepsy
___Other____

List all allergies:____

List all fractures/dislocations:____

List all surgeries:____

What medications are you currently taking?____________________________

____

Do you smoke tobacco? Yes / No If yes, amount per day_____,
how many years_____.

Do you drink alcohol? Yes / No If yes, amount per week_______________.

I hereby give permission to Dr. Robert Lim and his associates to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and treatment of my foot and/or ankle condition. I hereby give permission to Dr. Lim and his associates to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize payment directly to Dr. Robert Lim for the claim expenses as provided. I fully understand that I am liable for all charges including any amount my insurance company does not cover.

Signature_____________________________________Date_______________