GARY J. KAISERMAN, D.P.M.

DOCTOR OF PODIATRIC MEDICINE
FOOT SPECIALIST

PRESTON FOREST MEDICAL CTR.
5925 FOREST LN. #116
DALLAS, TX 75230
Telephone 972 387-3666

BROOKLAWN VILLAGE
2431 W. KIEST BLVD.
DALLAS, TX 75233
Telephone 214 339-2133

NAME _____ DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

RES. PHONE _____ SEX _____ MARITAL STATUS M _____ S _____ W _____ D _____

EMPLOYED BY _____ BUS. PHONE _____ OCCUPATION _____

MY FOOT PROBLEM IS _____

SOCIAL SECURITY NO. _____

MEDICAL INSURANCE

1. _____ NUMBER _____

2. _____ NUMBER _____

NAME OF (HUSBAND / WIFE) OR A PARENT _____

EMPLOYED BY _____ PHONE _____ OCCUPATION _____

MEDICAL INSURANCE _____

EMERGENCY - NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU _____

NAME _____ PHONE _____

ADDRESS _____ ZIP _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

NAME _____ ADDRESS _____

MEDICAL AND PODIATRY INFORMATION : _____

FAMILY DOCTOR _____ LAST VISIT _____

PODIATRIST _____ LAST VISIT _____

ANSWER ALL QUESTIONS BY CHECKING YES OR NO, OR FILL IN BLANKS:

1. Are you in general good health ..... YES NO
2. Are you presently under a doctor's care? ..... YES NO
3. Are you taking any drugs of medicine? Please list ..... YES NO

_____

4. Have you had any serious illness or operations? ..... YES NO
5. Have you or any family member been tested for DIABETES ? ..... YES NO
6. Circle any of the illnesses below that you have had: Heart Trouble High Blood Pressure Diabetes Kidney Liver Asthma
   Rheumatic Fever Arthritis Ulcers Stroke Tuberculosis Circulation
7. Are you now or have you recently taken any "cortisone like" or "blood thinning" medicines? YES NO
8. Arw you allergic to any of the following? Local anesthetic____ Penicillin ____ Tape ____ Asprin____ Iodine ____
   Antibiotics_____ Other _____
9. Do you have bleeding tendencies? YES NO Do you have pain in your heels or arch? YES NO
10. Do you have leg cramps? YES NO Do you have low back pain? YES NO

All patients are expected to pay for their charges in full on the first visit. Arrangements must be made with the bookeeper in advance, if these policies create an undue hardship. If any account becomes delinquent or is placed with an attorney, I agree to pay all attorney and collection fees. I hereby give my permission to Dr. Gary J. Kaiserman to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my foot condition.

SIGNATURE

DATE: _____ PARENT OR GUARDIAN _____