BERMUDA
PODIATRY CENTRE

Neil J. Moncrieff, D. Pod.M., M.Ch.S., S.R.Ch.

WELCOME TO OUR OFFICE

Completion of the following questionnaire regarding your medical history and present condition will assist us in the diagnosis and treatment of your foot condition. All information will, of course, be a part of your confidential podiatric record.

Last Name:_____ First Name/M.I.:_____

Address: _____ Parish: _____ Postcode: _____

Mailing Address: _____

Telephone: _____ Cell Phone: _____

Email Address: _____

Birthdate: Day_____ Month _____ Year _____ Sex: M F Marital Status: M S W D

How did you learn about this office? _____

Employer: _____

Primary Insurance Coverage: _____ Subscriber: _____

Certificate #:_____ Group #: _____

Name of family physician: _____

Are you under other physical care? Yes No If yes, name of other doctor: _____

Please list current medication, (if unsure of names, list their purpose, i.e. pressure pills, water pills, etc.)

_____

_____

To the best of your knowledge, do you now hoave or have you ever been treated for any of the following:

Heart Condition	☐	Stroke	☐	High Blood Pressure	☐
Gout	☐	Arthritis	☐	Diabetes	☐
Hepatitis	☐	H.I.V./AIDS	☐	Epilepsy	☐
Stomach Ulcers	☐	Venereal Disease	☐	Kidney Condition	☐
Liver Condition	☐	Prolonged Bleeding	☐	Asthma	☐
Tumor	☐			Slow Healing	☐

Have you ever had surgery or been hospitalized? Yes No

As far as you know are you allergic to any medication or substance? Yes No

AUTHORIZATION TO RELEASE INFORMATION AND PAY INSURANCE BENEFITS.

I hereby authorize Neil J. Moncrieff, D. Pod. M. and/or any other associate to render podiatric medical services to me/my minor child _____ and to release any information regarding diagnosis and treatment of myself (or my child) to my Insurance Co. regarding my claim. Also by my signature I authorize payment directly to the Bermuda Podiatry Centre of benefits. I understand that I am responsible for any amount not covered by my insurance Company.

DATE: _____ **SIGNATURE:** _____