

ROBERT WEAVER, D.P.M., F.A.C.F.A.S.
510 FIFTH AVENUE
CHARDON, OHIO 44024
(440) 286-4945

PATIENT NAME: _____

SPOUSE/LEGAL GUARDIAN: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # () _____ CELL# _____ SOCIAL SECURITY # _____

SEX ___ DATE OF BIRTH _____ AGE _____ WEIGHT _____ HEIGHT _____ SHOE SIZE _____

EMPLOYER _____ WORK PHONE # _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EITHER FILL OUT THIS PORTION OR WE CAN COPY YOUR INSURANCE CARD INSTEAD

PRIMARY INSURANCE _____ SECONDARY _____

COVERED EMPLOYEE _____

EMPLOYEE DATE OF BIRTH _____

I.D. # _____ GROUP # _____

CIRCLE ALL THAT APPLY TO YOU: DIABETES: INSULIN DEPENDANT? NON-INSULIN DEPENDANT?
 HEART DISEASE? YES OR NO
 HIGH BLOOD PRESSURE? YES OR NO
 KIDNEY DISEASE? YES OR NO

LIST ANY ALLERGIES TO MEDICATIONS _____

LIST ANY MEDICATIONS YOU ARE TAKING OR WE CAN COPY YOUR LIST _____

WHAT FOOT PROBLEMS ARE YOU HERE FOR TODAY? _____

WHO IS YOUR FAMILY PHYSICIAN? _____ PHONE # _____
ADDRESS _____ CITY _____ ZIP _____

WHO REFERRED YOU TO OUR OFFICE? _____ DO YOU NEED A
REFERRAL
FROM YOUR FAMILY PHYSICIAN? _____

CAN WE LEAVE A MESSAGE AT YOUR HOME OR ON YOUR MACHINE OR VOICE MAIL? _____

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE DR. WEAVER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDANTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE AND I AGREE TO PAY FOR FEES INVOLVING PAST DUE COLLECTION.

YOUR SIGNATURE _____ TODAY'S DATE _____