Kathleen Daly DPM
10431 S Kedzie Chicago, Illinois 60655
(773)239-8660

Patient Information

Name_____ Age_____Date of Birth_____
Address_____ Home Phone_____
City, State, Zip Code_____ Work No._____
Marital Status _____ Cell No._____
E-mail:_____**This is for accessible health record information only
{} Patient does not have an e-mail address
{}Patient does not want to disclose e-mail address

Social Security number_____**Needed for billing purposes if you use insurance
Employed: Yes_____No_____Student_____Occupation_____
Employer_____Address_____
**Whom may we thank for referring you to our office:_____

Insurance Information

Responsible Party Name_____Self_____Spouse_____Parent_____
Date of Birth of Insured Person if parent or spouse_____
Insured's Employer_____
Address_____

Primary Insurance Company_____
**we will make a copy of your card(s) as well as a form of picture ID

Medical Information

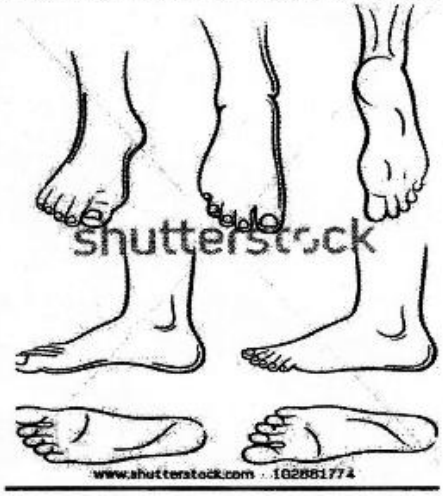
Family Physician_____Last Medical Examination_____

List any Allergies_____
List any Medications you are taking or we can make a copy of your list_____

Do you now have, or have you ever had, any of the following: If no, leave blank

Diabetes____ Heart Problems: Atrial Fib____Heart Attack_____Stent_____Stroke____
High Blood Pressure____ High Cholesterol____ Gout____ Kidney Problems____
Liver Disease____ Emphysema____ Artificial Joint: Knee_____ Hip_____
Glaucoma____ Macular Degeneration____
Circulation Problems: Varicose Veins_____ Blood Clots_____ Peripheral Arterial Disease_____
Cancer____
Surgeries_____

Mark an X on an area of the foot where your pain or problem appears to be.



YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE PLAN

Please sign: I authorize the release of any medical information necessary to process this claim. I authorize the payment of medical benefits to Dr. Kathleen Daly. I understand I am responsible for all costs of treatment.

Signature (insured or authorized person)
_____

Relationship Self_____Parent_____
Caregiver_____

Date_____