

DRS.TAYLOR AND OSTERMAN, P.A.
DR. SAYLEE TULPULÉ

NEW PATIENT INFORMATION SHEET

LAST NAME _____ FIRST/MI _____
STREET _____ CITY _____ STATE _____
ZIP CODE _____ HOME PHONE _____ DOB _____
CELL PHONE _____ E-MAIL _____
SSN _____ - _____ - _____ SEX M or F WT: _____ HT: _____

NEW HEALTH CARE REGULATIONS REQUIRE WE ASK THE FOLLOWING:

RACE: ___ Not Specified ___ Asian ___ Black or African American ___ White
___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander

ETHNICITY: ___ Not Specified ___ Hispanic or Latino ___ Not Hispanic or Latino

PRIMARY LANGUAGE: _____

EMPLOYER _____ WORK NUMBER _____
FAMILY DOCTOR _____ DATE LAST SEEN _____
FORMER PODIATRIST _____ DATE LAST SEEN _____
EMERGENCY CONTACT _____ PHONE _____
WHO REFERRED YOU TO THIS OFFICE _____

HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO	
()	()	CRAMPS AND NUMBNESS IN FEET/LEGS	()	()	LIVER TROUBLE
()	()	SWELLING IN FEET OR ANKLE	()	()	RHEUMATIC FEVER
()	()	HIGH BLOOD PRESSURE	()	()	VARICOSE VEINS
()	()	HEART DISEASE	()	()	ARTHRITIS
()	()	DIABETES	()	()	ANEMIA
()	()	TUBERCULOSIS	()	()	EAR TROUBLE
()	()	ASTHMA	()	()	BLOOD DISEASE
()	()	KIDNEY DISEASE	()	()	LOW BACK PAIN
()	()	EYE TROUBLE	()	()	PROFUSE BLEEDING
()	()	FRACTURES/BROKEN BONES	()	()	DO YOU SMOKE
()	()	ULCERS(PEPTIC/DUODENAL)	()	()	HIV+/AIDS
()	()	RESPIRATORY PROBLEMS	()	()	DRINK ALCOHOL

DO YOU HAVE ANY ALLERGIES? IF YES PLEASE LIST THEM:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

Name of Medicine Dosage Reason for taking this medication

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY REASON IN THE PAST 5 YEARS?

Name of Hospital Date Reason for hospitalization

WHAT IS THE NATURE OF YOUR COMPLAINT?

_____ **WHEN DID IT START** _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) WIFE HUSBAND PARENT OTHER

LAST NAME _____ **FIRST/MI** _____
STREET _____ **CITY** _____ **STATE** _____
ZIP CODE _____ **HOME AND WORK NUMBER** _____
DATE OF BIRTH _____

INSURANCE HOLDER EMPLOYERS NAME _____
STREET _____ **CITY** _____ **STATE** _____
ZIP CODE _____ **PHONE NUMBER** _____

PRIMARY INSURANCE COMPANY

INSURANCE NAME _____

POLICY# _____ **GROUP#** _____

SUBSCRIBERS NAME IF OTHER THAN PATIENT _____

ADDRESS _____

PHONE # _____ **DATE OF BIRTH** _____

SSN _____

SECONDARY INSURANCE

INSURANCE NAME _____

POLICY# _____ **GROUP#** _____

SUBSCRIBERS NAME IF OTHER THAN PATIENT _____

ADDRESS _____

PHONE# _____ **DATE OF BIRTH** _____

SSN _____

I understand that failure to provide all pertinent patient information can lead to denial in my claim, therefore I will be held 100% responsible for the visit. Please make sure that you have a referral if needed by your primary care doctor. I understand that failure in bringing the necessary referral will hold me 100% responsible for services rendered. If you wish to make payment, you may do so by cash, check or credit card.

SIGNATURE _____ **DATE** _____