FEET FIRST FOOT CARE SPECIALISTS, LLC
ADAM MUCINSKAS, DPM
162 WEST STREET SUITE K CROMWELL, CT 06416
Phone: 860-632-5499 Fax: 860-632-5515
Diplomat American Board of Foot and Ankle: Certified in Foot Surgery

Date _____
Name _____ Age_____ Date of Birth_____

Address_____City_____
State _____ Zip_____
Phone (day) _____ (evening) _____
e-mail address (for appointment reminders):_____

Occupation_____
Employer _____City _____
State_____ Phone _____

Social Security Number _____
Emergency Contact_____
Phone (day) _____ (evening) _____

Who may we thank for referring you to this office? _____

Insurance Information
Primary Insurance _____
ID Number _____ Group Number_____
Name on account_____

Secondary Insurance _____
ID Number _____ Group Number_____
Name on account_____

Family Physician_____
Address _____
Date of last exam_____

Pharmacy Name_____ Phone: _____

Please list any medications you are currently taking:

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? _____ If so, please list:

Allergen:	Reaction (Hives, Difficulty Breathing, Anaphylaxis, Other):
_____	_____
_____	_____
_____	_____

Height: _____ Weight: _____ Shoe Size: _____

Please describe current foot problems:

_____

_____

Do you have a family history of any of the following?

_____ Diabetes
_____ Cancer
_____ Heart disease
_____ High blood pressure

Have you ever experienced any of the following?

_____ Stomach problems
_____ Ulcers
_____Liver problems
_____ Numbness
_____ Strokes
_____ Seizures
_____ Spinal problems
_____ Visual problems
_____ Heart attack
_____ Rapid heart beat
_____ High blood pressure
_____Other: Please list:
_____ Varicose veins
_____ Congestive heart failure
_____ Asthma
_____Emphysema
_____ Cancer
_____ Arthritis
_____ Sciatica
_____ Anemia
_____ Bleeding disorders
_____Diabetes

_____

_____

Do you smoke?_____ If so, how much? _____

Any history of drug or alcohol use? _____ If so, please explain:

_____

_____

Please list any history of surgeries or hospitalizations

_____

_____

Assignment and release:

I hereby authorize payment directly to Dr. Adam Mucinskas all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____Date_____