**Richard I. Reaback, D.P.M**
Diplomat, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle surgeons

**300 Hebron Avenue, Suite 104**
**Glastonbury, CT 06033-2176**
**Tel: (860) 633-9004**
**Fax: (860) 633-1642**

Date:_______________ Chart #_______________________

Name:___________________________________Age:________Date of Birth__________________
Social Security Number:___________________

Address:_______________________________________________City:__________________
State:_______________Zip:______________
Phone (day):__________________(evening):_______________(cell):________________

Occupation:__________________________________________
Employer:_________________________________________ City:___________________
State:________________________________Phone:_____________________

Emergency Contact:______________________________________________________________
Relationship_____________________________________________________________________
Phone (day):________________________(evening)_______________________
Who may we leave a message with:_____________________________________

Family Physician: ______________________________________________________
Address:___________________________________________________________
Date of your last exam: Month:__________Day:__________Year:___________

Who may we thank for referring you to our office?_________________________

Insurance information

Primary Insurance: ____________________________________________
ID Number: ____________________________Group Number:_________________________
Name of Primary card holder:_________________________ Date of Birth _______________
Relationship_______________

Secondary Insurance:__________________________________________
ID Number:____________________________GroupNumber:___________________________
Name of Primary card holder:______________________ Date of Birth:___________________
Relationship________________

Pharmacy Name_________________________________Phone:________________________

Please list any medical conditions you are currently being treated for:

______________________________________________________________________

______________________________________________________________________

Please list any medications you are currently taking:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Are you allergic to any medications? Yes/No Please list if any:____________________

______________________________________________________________________

Height:____________________Weight:____________________Shoe Size:____________

Please describe current foot problems:

______________________________________________________________________

______________________________________________________________________

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

| | |
|---|---|
| ____ Diabetes | ____ Heart Disease |
| ____ Cancer | ____ High Blood Pressure |

Have you ever experienced any of the following?

| | | |
|---|---|---|
| ____ Stomach Problems | ____ Varicose Veins | ____ Ulcers |
| ____ Congestive Heart Failure | ____ Liver Problems | ____ Asthma |
| ____ Numbness | ____ Emphysema | ____ Strokes |
| ____ Cancer | ____ Seizures | ____ Arthritis |
| ____ Spinal Problems | ____ Sciatica | ____ Visual Problems |
| ____ Anemia | ____ Heart Attack | ____ Bleeding Disorders |
| ____ Rapid Heart Beat | ____ Diabetes | ____ High Blood Pressure |
| ____ HIV | ____ High Cholesterol | |

____ Other: Please List: ______________________________________________

______________________________________________

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:______________________________

______________________________________

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***Assignment and release:***

_______I hereby authorize payment directly to Dr. Richard Reaback. I understand that I am financially responsible for all charges whether or not paid by my 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 submission.

_______I have received a copy of the Notice of Privacy Practices.

Print Name:______________________________________

Signature of Responsible Party:______________________________________

Relationship to Responsible Party:____________________________________

Date:_________________________