

Robert Lim, DPM  
National Athletic Ankle & Foot Institute

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PATIENT INFORMATION (Please Print)

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Marital Status \_\_\_\_\_ Shoe size \_\_\_\_\_

In Case of Emergency, Contact \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

INSURANCE INFORMATION

Primary Insurance Co. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

## HEALTH HISTORY

Foot/Ankle Complaint(s) \_\_\_\_\_

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How long have you had the problem(s)? \_\_\_\_\_

Medical History, Please check if you have or had any of the following conditions:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Circulation/Bleeding Problems
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Kidney Condition	<input type="checkbox"/> Liver Condition
<input type="checkbox"/> Asthma/Lung Condition	<input type="checkbox"/> Cancer (Location _____)
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Stomach/Intestinal Condition
<input type="checkbox"/> Gout	<input type="checkbox"/> Artificial Joints or Valves
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Muscle Disease (MS, Polio)
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Blood Disease (Anemia, Sickle Cell)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Other _____	

List all allergies: \_\_\_\_\_

List all fractures/dislocations: \_\_\_\_\_

List all surgeries: \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

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Do you smoke tobacco? Yes / No If yes, amount per day \_\_\_\_\_,  
how many years \_\_\_\_\_.

Do you drink alcohol? Yes / No If yes, amount per week \_\_\_\_\_.

I hereby give permission to Dr. Robert Lim and his associates to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and treatment of my foot and/or ankle condition. I hereby give permission to Dr. Lim and his associates to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize payment directly to Dr. Robert Lim for the claim expenses as provided. I fully understand that I am liable for all charges including any amount my insurance company does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_