Jawad A. Malik, D.P.M.,P.A.
Podiatric Medicine & Surgery

710 Governors Ave Orlando, FL 32808 Phone (407) 913-3965 Fax (407) 290-8464

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELLPHONE _____

BIRTH DATE _____ AGE _____ SOC. SEC. # _____

WEIGHT____ HEIGHT_____ EMAIL ADDRESS_____

PLEASE CIRCLE: FEMALE/ MALE, MARRIED, SINGLE, OTHER _____

MEDICARE # _____ MEDICAID # _____

INSURANCE CO. _____ POLICY # _____

EMPLOYER'S NAME _____ PHONE # _____

ADDRESS _____ OCCUPATION _____

PERSON RESPONSABLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)

INSURANCE CO. _____ POLICY # _____

INSURED NAME _____ PHONE # _____

ADDRESS _____

SOC. SEC. # _____ RELATION TO PATIENT _____

EMPLOYER'S NAME _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

INSURANCE CLAIM AUTHORIZATION LIFETIME SIGNATURE

I authorize any holder of medical information concerning myself to release to the Health Care Financing Administration (HCFA) and its agents or carriers any information needed for this or a related Medicare claim. I request that payment of authorized medical benefits be made on my behalf to **Jawad A. Malik, D.P.M., P.A.** for physician services furnished by him and/or his professional associates. I request that this authorization will also apply to all other medical insurance.

PATIENT SIGNATURE _____ DATE _____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

GENERAL MEDICAL INFORMATION:

MEDICAL DOCTOR _____ ALLERGIES _____

PAST MEDICAL HISTORY:

HAVE YOU EVER BEEN TREATED FOR: (PLEASE CIRCLE)

DIABETES	ANEMIA
HIGH BLOOD PRESSURRE	ASTHMA/ EMPHYSEMA
GOUT	TB
RHEUMATIC FEVER	EPILEPSY
HEART DISEASE	THYROID DISEASE
HIGH CHOLESTEROL	CANCER
STROKE	HIV
KIDNEY/ LIVER DISEASE	ARTHRITIS
STOMACH/ INTESTINAL DISORDERS	PHLEBITIS/ VENOUS DISEASE
CIRCULATORY PROBLEMS	MENTAL ILLNESS: _____

SOCIAL HISTORY: Cigarette smoking_____Alcohol _____

PAST SURGERIES _____

MEDICATIONS _____

_____

Pharmacy:_____ Phone: _____ Fax:_____

ABOUT YOUR FEET:

BRIEFLY DESCRIBE YOUR FOOT PROBLEM:_____

THIS PROBLEM INVOLVES THE: (Please Circle) RIGHT FOOT LEFT FOOT BOTH FEET

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

DID YOU HAVE TREATMENT? _____ RESULTS? _____

HOW DID YOU HEAR ABOUT US ? _____

AUTHORIZATION FOR TREATMENT / AUTORIZACION DE TRATAMIENTO

I hereby authorize Dr. Jawad A. Malik, D.P.M. and/ or his associates to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles and/or legs.
(Yo autorizo al Dr. Jawad A. Malik, D.P.M. y/o asociados a evaluar, examinar y realizar los procedimientos necesarios para el tratamiento de mis pies, tobillos y/o piernas).

PATIENT SIGNATURE _____ DATE _____
(Firma) (Fecha)