Yuko Miyazaki, DPM
3000 Colby St, Suite 107 Berkeley, CA 94705
Phone: 510-647-3744 FAX: 510-764-2446

Patient Name_____Age_____**Date of Birth**_____
Home Address_____City _____State_____
ZiP_____**Home Phone**_____**Cell**_____
Work_____Email_____
Patient Employed By_____Occupation_____
Subscriber of Insurance: ( ) self ( )spouse( )parent, if it is spouse or parent, give us
Name of Subscriber_____ Date of Birth_____
Address_____City _____State_____
Secondary insurance subscriber;( ) self ( )spouse( )parent, if it is spouse or parent,
Name of Subscriber_____Subscriber Date of Birth_____
How did you hear about us? Doctor, Google, Yelp, Friend, Insurance site, other_____
Primary Physician_____Dr's Phone _____
Last PCP visit_____
Previous Treatment of feet by a Doctor ( ) No ( ) Yes When_____Whom_____

Chief Foot Concerns_____
Weight_____**Height**_____ **Shoe Size**_____
Are you in General Good Health? ( ) Yes ( ) No If not,
Why?_____
Past illness and/or Operations?_____
Medication You Now Use_____
Name and Address of Pharmacy Patient Uses_____
If you have had or have any of the following, please check (x)

( ) Diabetes	( )Low Back Pain	( ) Asthma	( )Arthritis
( )Blood Clot	( )Liver Trouble	( )Heart Trouble	( )Tuberculosis
( )Anemia	( )High Blood Pressure	( )Blood Disease	( )Rheumatic Fever
( )Stroke	( )Bleeding Disorder	( )Drug Reaction	( )Gout
( )Eye Trouble	( )Other_____		

If you are allergic or sensitive to any of following, Please Check (X)
( )Novocain ( )Penicillin ( )Sulfa ( )Adhesive Tape ( )Latex ( )Other_____

Do you smoke? NO, Yes: how much_____ Do you drink Alcohol? No, Yes how much_____

I hereby authorize Dr. Yuko Miyazaki permission to evaluate and treat my podiatric concerns. I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsive for non-covered services or supplies. I also authorize the release of medical information to the insurance company for purposes of billing for my treatment and to my pharmacy for prescription requests, if needed.

Date_____ Signature(Patient or Legal Guardian)_____