Yuko Miyazaki, DPM
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Phone: 510-647-3744 FAX: 510-764-2446

Patient Name _____Age _____**Date of Birth**_____
Home Address _____City _____
State_____ ZIP_____**Occupation**_____
Home Phone_____ **Cell**_____
Email_____
Gender: Male_____**Female**_____**NB**_____

Subscriber of Insurance: ( ) self ( ) spouse ( ) parent, if it is spouse or parent, give us
Name of Subscriber _____ Date of Birth_____
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 visit Primary Physician_____
Previous Treatment of feet by a Doctor ( ) No ( ) Yes When _____Whom_____

Chief Foot Concerns_____
Height _____**Weight**_____ **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	( ) Thyroid
( ) 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 responsible 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)_____