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DR. ALAN W. PITTLE  
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10500 Vista Del Sol  
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ACCT. # \_\_\_\_\_

## Patient Information

(Confidential Information - Important for Our Files and Your Health)

Patient \_\_\_\_\_  
LAST FIRST MI

Date of Birth \_\_\_\_\_ Sex : M / F Marital Status: S M D W

Street Address \_\_\_\_\_ Telephone \_\_\_\_\_

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

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Telephone \_\_\_\_\_ Social Security No. \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

## Medical History

Family Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Has he / she requested that you be seen in our office? \_\_\_\_\_

Former Podiatrist \_\_\_\_\_

Why did you see your former podiatrist? \_\_\_\_\_

What problems bring you to our office? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all medicines which you now use: \_\_\_\_\_

\_\_\_\_\_

**FOR WOMEN ONLY:** Are you pregnant? \_\_\_\_\_ If so, how many months? \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_

# Insurance Information

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Primary Insurance Name	Name of Insured	I.D. Number
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Secondary Insurance Name	Name of Insured	I.D. Number
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\*\*\*If patient is not the policy holder please fill out the following information:

Policy Holder's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

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

Zip Code \_\_\_\_\_ Sex ( M / F ) \_\_\_\_\_

Guarantor Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

## RELEASE AND ASSIGNMENT

TO MY INSURANCE CARRIER (S):

1. I authorize the release of any medical information necessary to process my insurance claim (s).
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that is authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.

\_\_\_\_\_  
Signed (Patient or Representative)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (Printed)

Please check "Yes" or "No" to indicate if you have had any of the following problems:

Yes	No	Nature of Problem	Comments and Give Approximate Date
		Allergies/Hay fever	
		Asthma	
		Allergic Reaction to Medication	
		<b>D i a b e t e s</b>	
		<b>S k i n</b>	
		<b>A n e m i a</b>	
		<b>H e a r t</b>	
		Circulation	
		High Blood Pressure	
		Chest Pain	
		Lungs (Pneumonia, TB, etc.)	
		Shortness of Breath (Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease (or Jaundice)	
		Stomach Trouble	
		Swelling in Feet or Ankles	
		Arthritis	
		Kidney Disease or Stones	
		Gout	
		Bleeding Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Low Back Pain	
		Do you Smoke? How Much?	
		Do you drink alcohol? How much?	
		Do you take drugs? (legal or illegal) How much?	
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		Pain in Other Areas	
		Other Illnesses or Problems	
		HIV Positive	

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Please give details of any:

<b>Operations/Serious Injuries</b>	<b>Approximate Date</b>	<b>Physician</b>	<b>Hospital</b>

Is there anything you wish to tell your physician privately?      Yes       No

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_