☐ **Brian O'Carroll, DPM** ☐ **Byron Collier, DPM**
911 Oak Park Blvd, Ste 106, Pismo Beach, CA 93449 t: (805) 481-9100 f: (805) 481-9199
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MEDICAL INFORMATION

Patient Name:	**Date of Birth:**
Reason for Visit:	
How long have you had this issue?	
Have you seen another Dr. for this problem? Name:	When:

Primary Care Physician:		**Date Last Seen:**
Did someone refer you to us?	☐ Primary Care Physician ☐ Hospital / ER	☐ Another Dr: _____ ☐ Another Patient: _____
Other Physicians you regularly see:		
Preferred Pharmacy:		
Preferred Lab:		
Preferred Imaging Center:		

Medication Allergies:			
Height:	**Weight:**		
Past Surgeries /Approximate Date:			
Tobacco Use: ☐ Never ☐ Former, # Years: ____ ☐ Current, Amt: _____per day/wk/mo			
Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy			
Please indicate any of the following conditions you have had or currently have:			
☐ Alcoholism	☐ Diabetes	☐ HIV	☐ Pacemaker
☐ Arthritis (Osteo)	☐ Gout	☐ Hip/Knee Replacement	☐ Stroke
☐ Arthritis (Rheumatoid)	☐ Heart Disease	☐ Hypertension	☐ Vascular Disease
☐ Cancer	☐ Hepatitis	☐ Kidney Disease	
☐ Other:			

Release of Information: I hereby authorize the above provider and his staff/business partners to 1) release to my insurance company and its agents, all information needed to determine benefits payable for related services, 2) process insurance claims generated in the course of examination or treatment; and 3) allow a photocopy of my signature to be used to process insurance claims.

Patient/Guardian Signature: _____ Date: _____