Gideon G Lewis MD (Family Practice) X Gideon J Lewis DPM (Foot and Ankle)

Welcome to Drs. Lewis and Lewis MD PA.

If you are a new patient or have not seen us for 3 years, please complete the following *pages* health history prior to your appointment. Feel free to ask for assistance from the staff or your provider if you are unsure how to answer a question. Please print your answers.

Date: _____

LAST Name:_____ **Title:** _____

FIRST Name: _____ **Middle Initial:** _____

Address: _____

City: _____ **State:**_____ **Zip Code:**_____

Sex (please circle): M or F

Social Security #: _____ **Date of birth:**_____/_____/_____
D M Year

Home phone:_____**Work phone:** _____

Cell Phone:_____**Email address:** _____

Primary Doctor: _____
(First Name, Last Name)

Referring Doctor: _____
(First Name, Last Name)

Marital Status (please circle) : Single Married Divorced Widowed

Student (please circle): Full-Time Part-Time

Spouse/partner Occupation (spouse/partner): _____

In Case of Emergency:

Name: _____Phone: _____

Relationship: _____

Preferred Method of Contact: (please circle one) Cell Phone Home Phone

Please state reason for today's visit: _____

Education: ☐ middle school ☐ high school ☐ college degree ☐ post college degree

Occupation/ Employer: _____

Do you have a "living will" or other advanced directive

Y or N If yes, where is it filed? _____

If no, would you like information today? ☐Yes ☐ No if yes, date given:_____nurses initials _____

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Date:_____

Insurance Information:

Responsible Party/Primary Insurance Policy Holder Information

Last Name:_____ DOB: _____/_____/_____
D M Year

First Name: _____ Middle Initial: _____

Phone:_____ Sex: M F

Email address: _____

Relation to Patient: _____ Social Security #: _____

Employer:_____ Work Telephone: _____

Insurance Plan Information:

Primary Insurance Company:_____ Effective Date: ____/_____/_____
D M Year

Plan (please circle): HMO PPO POS EPO

Member ID_____ Group #_____

Address:_____

City/State/Zip: _____ Policy Holder _____

Secondary Insurance Company:_____

Plan (please circle): HMO PPO POS EPO

Member ID_____ Group #_____

Address:_____

City/State/Zip: _____ Policy Holder _____

☐ Private Pay