

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Place of Employment and Address \_\_\_\_\_

Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ S M W D

Referred to this Office By \_\_\_\_\_

Who is Responsible for this Account? \_\_\_\_\_

Do you have Medical Insurance ? \_\_\_\_\_ Yes / No

Name of Company \_\_\_\_\_ Group # \_\_\_\_\_

I. D. # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medicare : Yes / No ID # \_\_\_\_\_

Family Doctor and Address \_\_\_\_\_

\_\_\_\_\_

Present Complaint \_\_\_\_\_

\_\_\_\_\_

This Involves my : Left Foot \_\_\_\_\_ Right Foot \_\_\_\_\_

Duration of this Problem \_\_\_\_\_

Have you had previous care by a Foot Specialist ? \_\_\_\_\_

Are you presently under a Physician's care ? \_\_\_\_\_

Are you taking medications at this time ( Prescription or over the counter ) ?

If yes please list \_\_\_\_\_  
\_\_\_\_\_

Do You Have, or Anyone in Your Family Have?

High Blood Pressure	_____	Relationship	_____
Heart Ailments	_____	Relationship	_____
Diabetes	_____	Relationship	_____
Arthritis	_____	Relationship	_____
Gout	_____	Relationship	_____
Epilepsy	_____	Relationship	_____
Hepatitis	_____	Relationship	_____
HIV	_____	Relationship	_____
Cancer	_____	Relationship	_____
Kidney Disease	_____	Relationship	_____
Stroke	_____	Relationship	_____

Any Other Medical Problems \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to, or have you ever had any effects from Novocaine, penicillin, or any other medications ? Please List \_\_\_\_\_  
\_\_\_\_\_

Any other information we should know? \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_