

APPOINTMENT, DATE		TIME	ACCT #
NAME, LAST		FIRST	MI
SS#	BIRTHDATE	SEX: M F	MARITAL STATUS:
HOME ADDRESS, PHYSICAL		CITY	STATE/ZIP
MAILING ADDRESS		CITY	STATE/ZIP
PHONES: HOME () -		CELL () -	WORK () -
SPOUSE(or Parent) NAME:		Work/Cell Phone:	
EMPLOYMENT (CIRCLE ONE)	FULL	PART-TIME	RETIRED NOT EMPLOYED
EMPLOYER			
WORK ADDRESS		CITY	STATE/ZIP
STUDENT (CIRCLE ONE) FULL or PART TIME		SCHOOL NAME:	
Full Name Family Doctor		LAST SEEN MO/YR	
DR'S ADDRESS		CITY	STATE/ZIP
I WOULD OR WOULD NOT LIKE A COPY OF MY INITIAL VISIT NOTES TO BE SENT TO MY			
FAMILY DOCTOR.		PATIENT SIGNATURE:	
Primary Insured or Responsible Party : If you are covered on someone else's policy (for example, your spouse or parent) or someone else is paying your bill, we MUST have the following information.			
NAME, LAST		FIRST	MI
SS#	BIRTHDATE:	SEX: M F	
ADDRESS, PHYSICAL		MAILING	
CITY	STATE/ZIP	HM PH () -	
EMPLOYER:		WK PH () -	
ADDRESS:		CITY	STATE/ZIP
HOW DID YOU HEAR ABOUT OUR OFFICE? (CIRCLE ONE) DRIVE-BY TV AJ INS CO			
FEIST	SWBYP'S	DR	PATIENT OTHER

PATIENT NAME	DATE:	ACCT #
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WHAT KIND OF FOOT PROBLEM(S) ARE YOU HAVING?

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DURATION: Years Months ANY PREVIOUS FOOT TREATMENT?

ALLERGIES (PLEASE, LIST)

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SOCIAL HISTORY (CIRCLE IF EVER USED) TOBACCO DRUGS ALCOHOL

LIST ALL SURGERIES			
YEAR	SURGERY TYPE	YEAR	SURGERY TYPE

FAMILY HISTORY Please, check all groups to which the problems or illnesses below apply.

	You	Brothers	Sisters	Mother	Father	Mother's Family	Father's Family
arthritis							
asthma							
bleeding							
cancer							
cerebral palsy							
circulation							
diabetes							
emphysema							
eye disorders							
gout							
heart							
hypertension							
kidney							
liver							
musculoskeletal/bone							
osteoporosis							
polio							
stomach ulcers							
stroke							
rheumatic fever							
other:							

