

# WELCOME TO OUR OFFICE

## PATIENT INFORMATION

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SPOUSE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ BUSINESS# \_\_\_\_\_ CELL # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS: S M D W

EMPLOYER \_\_\_\_\_ WHAT TYPE OF WORK DO YOU DO? \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMERGENCY CONTACT# (YOU MUST LIST THIS) \_\_\_\_\_ RELATION \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

## INSURANCE INFORMATION

INSURANCE CO. \_\_\_\_\_ CONTACT # \_\_\_\_\_

GROUP # \_\_\_\_\_ MEDICARE # \_\_\_\_\_

MEDICAID # \_\_\_\_\_ SUBSCRIBER # \_\_\_\_\_

SUBSCRIBERS S.S. # \_\_\_\_\_ SUBSCRIBERS D.O.B. \_\_\_\_\_

PATIENTS SOCIAL SECURITY # \_\_\_\_\_

PATIENTS RELATION TO PRIMARY INSURANCE HOLDER \_\_\_\_\_

## PODIATRY HISTORY

WHAT IS YOUR FOOT PROBLEM? \_\_\_\_\_ WHEN DID THIS START? \_\_\_\_\_

GRADE YOUR PAIN ON A SCALE OF 1-10 (0 IS THE LEAST, 10 IS THE WORST) \_\_\_\_\_ /10

HAVE YOU HAD TREATMENT FOR THIS BEFORE? YES NO

WHAT WAS THE TREATMENT? \_\_\_\_\_

HAVE YOU INJURED YOUR FEET/ANKLES BEFORE? YES NO

IF SO, HOW? \_\_\_\_\_

## MEDICAL HISTORY

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

PLEASE LIST YOUR CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER PRODUCTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ANY ALLERGIES: \_\_\_\_\_

DO YOU SMOKE? YES NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

DO YOU DRINK ALCOHOL, COFFEE, TEA OR SOFT DRINKS? YES NO

HOW OFTEN? \_\_\_\_\_