Foot Health Institute

Name:_____Sex: M___ F___

Date of Birth:_____Age:_____Social Security #:_____

Married____ Widowed____ Single____ Minor____ Separated____ Divorced____

Home Phone #:_____Cell Phone #:_____

Home Address:_____

City:_____State:_____Zip Code:_____

Email:_____

Employer:_____Work #:_____

Race: (circle) Declined Asian Black Indian White **Ethnicity**: Hispanic Non-Hispanic

Emergency Contact:_____Phone#:_____

Do you have insurance? YES NO

Insurance Company:_____

Insured Name:_____SSN:_____

Relation to Patient:_____Insured Date of Birth:_____

If Patient is a Minor, Parent Name:_____

Patient Signature:_____Date:_____

Guardian Signature:_____Relation:_____

Please list or circle where you found out about our office:

Internet/Google Insurance Family/ Friend Doctor Referral Facebook

Other:_____

Past Medical/Surgical Data

Operations: Date

_____
_____
_____

Past Hospitalization: Date/Year

_____
_____
_____

Chronic Illnesses: Date

_____
_____
_____

Allergies:

_____
_____
_____

Prescription Medicine:

_____
_____
_____

HAVE YOU HAD?

Gout	YES OR NO
Anemia	YES OR NO
Cancer	YES OR NO
Diabetes	YES OR NO
Hepatitis	YES OR NO
Arthritis	YES OR NO
Phlebitis	YES OR NO
Heart Trouble	YES OR NO
Kidney Trouble	YES OR NO
Liver Disease/Jaundice	YES OR NO
Rheumatic Fever	YES OR NO
T.B./Valley Fever	YES OR NO
Stomach Problems	YES OR NO
Epilepsy/Seizures	YES OR NO
Asthma/Allergies	YES OR NO
Bleeding Problems	YES OR NO
High Blood Pressure	YES OR NO
Neurological Problems	YES OR NO
Metal Implants	YES OR NO
Tobacco Usage	YES OR NO
Alcohol Usage	YES OR NO
Drug Usage	YES OR NO
Are you nursing an infant	YES OR NO

Are you now or could you be pregnant? Y/N

Height_____Weight_____

What Brings You In Today?

_____

TREATMENT AND MEDICATION CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary and review my past medication history.

_____ _____
Signature of Patient, Parent, Guardian or Representative Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient