

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Patient full name:

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sex: M or F

Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status  Single  Married  Widowed  Separated  Divorced

Name of Spouse \_\_\_\_\_

Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

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

Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Job Title \_\_\_\_\_

Company Phone \_\_\_\_\_ Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Physician Phone \_\_\_\_\_ Physician Fax \_\_\_\_\_

Physician Address \_\_\_\_\_

Person responsible for services rendered if different than listed above

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## Patient Health Information

Please describe what brings you to the office today?

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Past Medical History

- Hypertension/ high blood pressure  
  HIV/AIDS  
  Hepatitis  
  Heart Attack/ Myocardial Infarction  
 Insulin dependent diabetes  
  Non-Insulin dependent diabetes  
  Stroke/Cardio Vascular Attack  
 Aneurysm  
  Blood Clot

Past Medical History – Injuries/Trauma

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Have you had any of the following foot surgeries?

- Toenail  
  Bunion  
  Hammertoe  
  Fracture/Repair  
  Joint Fusions  
 Tendon Repair/ Rerouting  
  Ankle Stabilization  
  Arthroscopy  
  Fasciotomy

Please list approximate month and year of any surgery listed above:

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Past Surgical History: Have you had any of the following surgeries?

- Heart Bypass  
  Heart Valve Repair/Replacement  
  Appendectomy  
  Gallbladder  
 Brain Surgery  
 Other \_\_\_\_\_

Please list approximate month and year of any surgery listed above:

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## Social History

Do you:

- Smoke Tobacco  
  Smoke Marijuana  
  Use Hallucinogenic Drugs  
  Drink Alcohol  
 Use Cocaine  
 Use other Recreational Drugs

Number of drinks per day:

- Greater than 5 per day  
 1-3 Drinks per week  
 4-6 Drinks per week  
 Social Drinking Only

Social Smoker, number of packs per day:

- 5 or more packs per day    1-2 packs per week    3-4 packs per week    Social Smoking Only

Medications- Please list all medications you are currently taking including aspirin:

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Do you have any of the following allergies:

- No Known Allergies    Drug allergies    Penicillin    Sulfa    Erythromycin  
 Aspirin    Cortisone    Codeine    Adhesive Tape    Local Anesthetics

Please list any other allergies to medications:

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**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I authorize payment of medical and surgical benefits to any physician and supplier for service described.  
I understand that I am responsible for all charges not covered by this authorization.

X \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize the release of any medical information necessary to process this claim.

X \_\_\_\_\_ Date \_\_\_\_\_