Welcome to Friendly Foot Care

(Please complete to the best of your ability)

Today's Date: _____________ Patient Name: ____ Sex: M F

Address: ____

City: ___________________________________ State: ______ Zip: ____________

Phone: (____) __________________ Cell: (____) ________________ Work: (____) ______________

Patient's SSN: (**required**) _______-_____-_________ Patient's Birth Date: _____/_______/________

Patient's Email address: ____

Marital Status (circle): Single Married Divorced Separated Widow Partner Child

Spouse's Name: ____________________________ Spouse's Birth date: ____/_____/_______

Spouse's SSN: _______-____-__________ Spouse's Phone (cell): (____) ________________

What contact method do you prefer our office use to contact you? Telephone? H C W or/both **Email**? Y N
If we contact you by telephone, is it ok to leave a message? Y N

Patient's Employer ____ Phone: (___) ___________________

Employer Address: ____________________________________ City, ST, Zip _________________________

Spouse's Employer ____ Phone: (___) ___________________

Spouse's Employer Address: _____________________________ City, ST, Zip _________________________

Are you currently residing in a nursing home? Y N *which one?* _______________________________

In Case Of Emergency, Notify: ______________________________________ Phone: (____) ______________

Race (circle): American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Black/African American White Hispanic Other

Ethnicity (circle): Hispanic/Latin Not Hispanic/Latin **Language** (circle): English Indian Spanish Russian Other

How did you hear about our office? (Circle) Post-Tribune NWI Times Internet Facebook Doctor

Yellow Pages Patient Insurance *Please be specific*____

Insurance Information

Primary Ins. Carrier: ____ Self Spouse Parent

ID # _______________________________ Group #: ______________ Plan: _____________

Insured's Name: ___________________________________ Insured's Birth date: ______/______/________

Insured's SSN: _______-______-_________ Insured's Home Phone: (___) ___________________

Insured's Address: ____City/State/Zip_____________________

Insured's Employer ____ Phone: (___) _________________

Secondary Ins. Carrier: ____ Self Spouse Parent

ID # _______________________________ Group #: ______________ Plan: _____________

Insured's Name: ___________________________________ Insured's Birth date: ______/______/________

Insured's SSN: _______-______-_________ **Patient Signature**: __________________________________

Please Provide the Following Important Medical Information to the Best of Your Ability

Patient Name: ____ Date: ______________________

Do you have any allergies to medications or substances? YES NO (circle) If YES, list all allergies: ______

____

If you are female, are you nursing currently or could you be pregnant? YES NO

Past Medical History:

1. Please check the "Yes"/"No" box if you have any of the following illnesses; for "Yes" answers, please explain.

	YES	NO	EXPLAIN HERE		YES	NO	EXPLAIN HERE
Diabetes	☐	☐	________________________	Stomach/Intestinal Problems	☐	☐	________________________
High Blood Pressure	☐	☐	________________________	Circulation Problems	☐	☐	________________________
Thyroid Problems	☐	☐	________________________	Kidney Problems	☐	☐	________________________
Heart Problems	☐	☐	________________________	Bone or Joint Problems	☐	☐	________________________
Prior Ankle Sprains	☐	☐	________________________	Neurological Problems	☐	☐	________________________
Blood Clot	☐	☐	________________________	Skin Cancer or Melanoma	☐	☐	________________________
Other Medical Problems	☐	☐	________________________				

____

2. Please list any operations that you have ever had (and their dates):______________________________________

____

3. Are you taking any medications or vitamins? YES NO (circle) If YES, **list** all current medications (and amounts, times per day) include aspirin, vitamins, herbal supplements, antacids, birth control, creams, and ointments):

____

____

____

4. Which pharmacy do you use? (Include address, city, state and telephone number)

____

PLEASE NOTE – PRESCRIPTIONS WILL BE SENT TO YOUR PHARMACY ELECTRONICALLY BY THE END OF THE DAY

5. Do you permit us to obtain your prescription history from your pharmacy? (circle) Yes No

6. Primary Care Physician (name and phone number) ____

	YES	NO	
Do you smoke?	☐	☐	If "yes", how much? _________________________________
If no, did you smoke previously?	☐	☐	If "yes", when did you quit? _________________________
Do you do any illegal drugs?	☐	☐	If "yes", list them. _________________________________

How often do you drink alcohol? _______________________

What is your occupation? ____

Is today's visit a result of an accident or injury? Y N If yes, is it work related? Y N If yes, please provide your Workers Comp information. If it is an accident or injury, is it part of a liability case? Y N

Family History:

Please check the "Yes" or "No" box if any relatives have any of the following illnesses/problems:

	YES	NO	RELATIVE		YES	NO	RELATIVE
Diabetes	☐	☐	________________________	Blood Clot	☐	☐	________________________
High Blood Pressure	☐	☐	________________________	Circulation Problems	☐	☐	________________________
Thyroid Problems	☐	☐	________________________	Skin cancer or melanoma	☐	☐	________________________
Cancer	☐	☐	________________________	Neurological Problems	☐	☐	________________________
Other Medical Problems	☐	☐	________________________				