Welcome to Friendly Foot Care

(Please fill in this page as best as you are able)

Today's Date: ________________ Patient Name: ______________________________________ Sex: M F

Address: ____

City: __________________________________ State: ______ Zip: ____________

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

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

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

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

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

Patient's Email address: ____

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**: ________________________________

Welcome to Friendly Foot Care
Please Provide the Following Important Medical Information to the Best of Your Ability

Patient Name: ____ Date: ____________________

Do you have any allergies? YES NO (circle) If YES, list all allergies: ______________________________

____

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

Past Medical History:
1. Please check the "Yes" or "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	☐	☐	____________
Bleeding/Blood Problems	☐	☐	____________				
Other Medical Problems	☐	☐	____________				

____

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

____

____

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):

____

____

____

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

____

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

	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? ______________________________

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

	YES	NO	RELATIVE		YES	NO	RELATIVE
Diabetes	☐	☐	____________	Bleeding/Blood Problems	☐	☐	____________
High Blood Pressure	☐	☐	____________	Circulation Problems	☐	☐	____________
Thyroid Problems	☐	☐	____________	Arthritis	☐	☐	____________
Heart Problems	☐	☐	____________	Neurological Problems	☐	☐	____________
Other Medical Problems?	☐	☐	____________				