family foot docs

PATIENT INFORMATION FORM
www.familyfootdocs.com (816) 452-1211

Date: _____

Name _____

Sex □Male □Female

Social Security # _____/_____/_____

Date of Birth_____/_____/_____ **Age** _____

Email address_____

Address_____

_____
City State Zip Code

Home Phone_____

Work Phone_____ Ext._____

Cellular Phone_____

Family foot docs may leave detailed messages on:

□ Home phone □ Cell phone □ Work phone

Family Physician _____

_____
City/State or Affiliation Phone#

Last Medical EXAM: _____

Primary Language: _____

Race:

□American Indian/Alaska Native □Asian

□African American □White

□Native Hawaiian/Pacific Islander

Ethnicity:

□Hispanic/Latino □Non-Hispanic/Latino

Marital status:

□Single □Married □Divorced □Widowed

Employer _____

Occupation _____

Address_____

_____
City State Zip Code

INSURANCE INFORMATION

Subscriber's Name_____

Relationship to patient_____

Birth Date_____ SS#_____

Insurance Co._____

ID#_____

Group#_____ Co-Pay_____

Is patient covered by other ins.? ▫Yes ▫ No

If yes please fill in secondary information below

Subscriber Name_____

Birth date_____ SS#_____

Relationship to patient_____

Insurance Co._____

ID#_____

Group#_____

How DID YOU HEAR ABOUT US?

Please Give Names

□Friend _____

□Doctor _____

□Other_____

□Internet

I authorize that family foot docs can release information in regards to my health care to the following person:

Name: _____

Relationship: _____

Phone# _____

Current Medications (including OTC): ▫NONE

_____

_____

List any medications you have allergies to:▫NONE

_____

Pharmacy Name_____

Health Habit: Check the substances and circle the correct option.

▫caffeine (coffee/tea/cola) ▫drugs past/present

▫tobacco past/present/never ▫ alcohol past/present

Occupation: Check if your work exposes you to the following:

▫Stress ▫heavy lifting ▫hazardous substances

▫Other_____

Family History:

Father ▫ Alive ▫Deceased

Mother ▫ Alive ▫Deceased

	No. Alive	Health	No. Deceased
Brother's	_____	_____	_____
Sister's	_____	_____	_____
Children	_____	_____	_____

Check any illness that has occurred in a family member.

▫Diabetes Mother/Father/Other_____

▫Bleeding Tendencies Mother/Father/_____

▫High Blood Pressure Mother/Father/_____

▫Heart Disease Mother/Father/Other_____

Check if you are current with the following:

▫All childhood immunizations

▫Influenza vaccination ▫Tetanus

YOUR MEDICAL HISTORY

Check symptoms YOU currently have or have had in the past.

▫Acid Reflux
▫AIDS/HIV
▫Alcohol Dependence
▫Anemia
▫Anxiety
▫Arrhythmia
▫Arthritis
▫Artificial Joint/graft
▫Asthma
▫Bleeding Disorder
▫Blood Clots
▫Bowel Disorder
▫Bronchitis
▫Cancer History
▫Chills
▫Depression
▫Diabetes
▫Drug Dependence
▫Emphysema
▫Eye Problems
▫Fever
▫Fibromyalgia
▫Gout
▫Headaches
▫Hearing Problems
▫Heart Attack
▫Heart Disease
▫ Heart Murmur
▫Hepatitis _____
▫High Cholesterol
▫Hypertension
▫Kidney Disease
▫Leg Pain
▫Lung Disease
▫Mitral Valve Prolapse
▫Multiple Sclerosis
▫Muscle Disease
▫Night Cramps
▫Osteoarthritis
▫Pace Maker
▫Parkinson
▫Poor Circulation
▫Psychiatric Illness
▫Rheumatoid
▫Shortness of Breath
▫Skin Conditions
▫Stomach Problems
▫Stroke
▫Swelling Phlebitis
▫Thyroid Disease
▫Transfusion
▫Tuberculosis
▫Ulcer
▫Varicose Veins
▫other_____

PLEASE LIST ANY SURGERY HISTORY:

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any error or omissions that I may have made in the completion of this form. I understand by supplying my personal email address, I am authorizing family foot docs to contact me via email. I understand that personal health information may be shared and authorize this.

X_____ _____

SIGNATURE **DATE**