family foot docs

6717 North Oak Trafficway, Gladstone MO 64118
www.familyfootdocs.com (816) 452-1211

Date: _____

Name _____

Sex □Male □Female

Social Security # _____/_____/_____

Date of Birth _____/_____/_____ **Age** ____

Address_____

_____

City State Zip Code

Email _____

Home Number_____

Cell Number_____

Work Number _____Ext_____

Family Foot Docs may leave detailed messages on:

□ Home □ Cell □ 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_____

INSURANCE INFORMATION

Policy Holder's Name_____

Relationship to patient_____

Birth Date_____ SS#_____

Insurance Co._____

ID#_____

Group#_____ Co-Pay_____

Is patient covered by other insurance.? Yes / No

If yes, please fill in secondary information below.

Policy Holder's Name_____

Birth date_____ SS#_____

Relationship to patient_____

Insurance Co._____

ID#_____

Group#_____

Referred by: (Please Give Names)

□ Friend _____

□ Doctor _____

□ Other _____

□ Internet

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

Name _____

Relationship _____

Phone Number _____

Current Medications (including OTC): □NONE

_____
_____
_____
_____
_____

List any medications you have allergies to
□NONE

_____
_____
_____
_____

Pharmacy Name _____
Location: _____

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
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Children	_____	_____	_____

Check any illness that has occurred in a family member.

□Diabetes Mother/Father_____
□Bleeding Tendencies Mother/Father_____
□High Blood Pressure Mother/Father_____
□Heart Disease Mother/Father_____

YOUR MEDICAL HISTORY

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

□Acid Reflux
□AIDS/HIV
□Alcohol Dependence
□Anemia
□Anxiety
□Arrhythmia
□Artificial Joint/graft
□Asthma
□ Bleeding Disorder
□ Blood Clots
□ Bowel Disorder
□ Bronchitis
□ Cancer History, type
_____
□ Cataract
□ COPD
□ Depression
□ Diabetes A1c_____
□ Dialysis
□ Drug Dependence
□ Emphysema
□ Fibromyalgia
□ Gout
□ Headaches
□ Hearing Problems
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Hepatitis A, B, C
□ High Cholesterol
□ Hypertension
□ Kidney Disease
□ Lung Disease
□ Lupus
□ Lyme Disease
□ Melanoma
□ Mitral Valve Prolapse
□ Multiple Sclerosis
□ Osteoarthritis
□ Pace Maker
□ Parkinson
□ Poor Circulation
□ Psoriasis
□ Psychiatric Illness
□ Raynaud's
□ Rheumatoid Arthritis
□ Seizure
□ Stroke
□ Thyroid Disease
□ Transfusion
□ Tuberculosis
□ Varicose Veins
□ Other
_____
_____
_____

Surgical 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 authorize release of medical information to my insurance carrier or requested physician to provide continuity of care.

X_____ _____

SIGNATURE **DATE**