PLEASE COMPLETE ALL LINES

NAME_____CHART NUMBER _____
ADDRESS_____ SEX: MALE_____FEMALE_____
CITY,,STATE,,ZIP_____ MARRIED___SINGLE___OTHER___
H(ME PHONE_____ DRIVERS LIC - # _____
CELL PHONE #t_____ INSURED'S NAME _____
SOCIAL SECURITY # _____ PRIMARY INSURANCE
BIRTH DATE._____ _____
NAME OF RESPONSIBLE PARTY ID #_____
SELF_____SPOUSE_____PARENTS GROUP #_____
RESPONSIBLE PARTIES ADDRESS SECONDARY INSURANCE COMPANY
_____ _____
RESPONSIBLE PARTIES PHONE #: ID #_____
_____ PATIENTS FAMILY DOCTORS NAME
PATIENT EMPLOYED BY: _____
_____ HOW WERE YOU REFERRED TO OUR OFFICE
SPOUSE EMPLOYED BY: _____
_____ IN CASE OF AN EMERGENCY PARTY TO NOTIFY
EMPLOYMENT ADDRESS _____
_____: THEIR PHONE #
WORK PHONE # _____ _____

DO YOU HAVE OR HAVE HAD:

Allergies to drugs or materials (penicillin tape, Codeine, etc)_____YES____NO____
Please list any Allergies_____
Previous: Injuries (type and date)_____
Previous surgeries (type and dates)_____
Are you currently in good health:_____ YES____NO____
Are you pregnant (if applicable)_____ YES____NO____
Do you smoke (more than one pack daily)_____YES____NO,___
Do you use Alcohol frequently_____YES____NO___
Do you take Medication (if so please list) _____
_____

DO YOU HAVE

Diabetes YES___ NO ___ Shortness of Breath YES___ NO ___Convulsions YES__NO___
Heart Trouble YES__ NO __ Asthma YES___ NO___ Numbness(feet) YES__NO___
Chest Pain YES___NO___ Ulcers(GI) YES___NO___ Paralysis YES___ NO___
Bleeding tendencies YES___NO___ Urinary Problems YES___NO___ Joint Pain YES___NO__
High Blood pressure YES___ NO___ Kidney Problems YES___NO___ Anemia YES___NO___
Circulation Problems YES__ NO__ Weight Loss YES__NO__ H IV positive YES___ NO___

I hereby give my permission to administer treatment; and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and ankle conditions.

SIGNATURE_____ DATE_____