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? 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"/"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 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 BUSINESS 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? _____

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	☐	☐	_____	Circulation Problems	☐	☐	_____
High Blood Pressure	☐	☐	_____	Arthritis	☐	☐	_____
Thyroid Problems	☐	☐	_____	Neurological Problems	☐	☐	_____
Heart Problems	☐	☐	_____	Other Medical Problems	☐	☐	_____
Bleeding/Blood Problems	☐	☐	_____				