Midtown Foot Clinic, PC & Midtown Surgical Center, LLC

PATIENT INFORMATION

Name:_____ Soc. Sec. #:_____
Last Name First Name Initial

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Date of Birth:_____

Sex: [] M [] F Age:_____ Marital Status: [] Single [] Married [] Widowed [] Separated [] Other

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Decline Information

Race: [] American Indian or Alaska Native [] Asian [] African American [] Caucasian
[] Native Hawaiian or Other Pacific Islands [] Other Race [] Decline Information

Preferred Language:_____ Family Physician:_____

Preferred Pharmacy:_____ Pharmacy Phone Number:_____

Preferred method of communication: [] Telephone [] Mail [] Email [] Mail [] Patient Portal

Whom may we thank for referring you?
[] Advertisement [] Event [] Family [] Friend [] Health Fair [] Insurance Company
[] Internet [] Phone Book [] Physician [] Previous Patient [] Other_____

Patient Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

In case of an emergency, contact:_____ Home Phone:_____

Relationship to patient:_____ Work Phone:_____

In case of an emergency, contact:_____ Home Phone:_____

Relationship to patient:_____ Work Phone:_____

Patient:_____

INSURANCE INFORMATION

Do you have Medicare? [] Yes [] No If Yes, ID #:_____

Do you have Medicaid? [] Yes [] No If Yes, ID #:_____

Primary Insurance Co._____ Phone:_____

Policy / Subscriber #:_____ Group #:_____

Address:_____ City/State:_____ Zip:_____

Insured Name:_____
Last Name First Name Initial

Social Security # of Insured:_____ Insured Date of Birth:_____

Relationship to Patient:_____ Insured Employed By:_____

Secondary Insurance Co._____ Phone:_____

Policy / Subscriber #:_____ Group #:_____

Address:_____ City/State:_____ Zip:_____

Insured Name:_____
Last Name First Name Initial

Social Security # of Insured:_____ Insured Date of Birth:_____

Relationship to Patient:_____ Insured Employed By:_____

Person responsible for payment, if other then patient:

_____ Phone #:_____
Last Name First Name Initial

Address:_____ City/State:_____ Zip:_____

Patient:_____

MEDICAL HISTORY & INFORMATION

Shoe Size:_____ Weight:_____ Height:_____

Do you have any artificial joints or limbs?
Hip, [] Yes [] No Knee, [] Yes [] No Other:_____

Please circle if you have or have had any of the following:

Anemia	Depression	Healing Trouble	Liver Disease	Sickle Cell
Arthritis	Diabetes	Heart Disease	Lupus	Stomach Trouble/Ulcers
Asthma/COPD	Epilepsy	Heel Spurs	Neurological Disorder	Stroke
Back Problems	Fibromyalgia	Hepatitis	Numbness in Feet/Legs	Thyroid Problems
Bleeding Disorder	Flat Feet	High Blood Pressure	Phlebitis	Tuberculosis
Blood Clots	Frequent Infections	HIV Positive / AIDS	PVD/ Circulation	Tumors
Bunions	Gout	Hyper-cholesterol	Rheumatic Fever	Varicose Veins
Cancer	GERD	Joint Pain/Stiffening	Scarring Tendency	Unexplained Weight Loss or Gain
Cramps in Feet/Legs	Hammertoes	Kidney Disease		

Please circle or list allergies or sensitivities:

Adhesive Tape	Ibuprofen (Advil, Motrin)	Seasonal
Aspirin	Iodine	Sulfa Drugs
Betadine	Local Anesthetics	Xylocaine
Codeine	Novocaine	Other_____
Demerol	Penicillin	_____
Food_____	Seafood	_____

Please circle if there is a family history of:

Arthritis	Cancer	Gout	High Blood Pressure
Bleeding Disorder	Circulation Problems	Hammertoe	Neurological Disorder
Blood Clots	Diabetes	Heart Disease	Numbness in Feet/Legs
Bunions	Flatfeet	Heel Spurs	Stroke

Patient:_____

MEDICAL HISTORY & INFORMATION

Mother: [] Living [] Deceased [] Cause of death:_____

Father: [] Living [] Deceased [] Cause of death:_____

Brother(s): [] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____

Sister(s): [] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____

Do you currently smoke? [] No [] Yes, how long?_____Number of pack(s) per day?_____

Did you previously smoke? [] No [] Yes, how long?_____Number of pack(s) per day?_____

Do you drink alcohol or beer? [] No [] Yes, how often?_____

Employment: Do you? [] Sit at job [] Stand at job [] Stand and walk at job [] Retired

What problems bring you to our office?

_____

_____

How long have you had these problems? _____

Have you had any past surgical procedures on your feet or ankles? [] No [] Yes

If yes, what was done and when

_____

_____

_____

_____