Podiatry Intake Form

Name:_________________________ Date of Birth: ____________________________
Address: ___________________________ Best Phone #: ____________________________
___________________________ Please Circle: Cell Home Work
___________________________ Email Address: ___________________________

Social Security Number: _______________________________

Marital Status: Married Divorced Single

Biological Sex: Male Female

Name of Primary Insurance Company: ____________________________________
Address: ____________________________ Phone: ________________________
____
____

Health insurance policy number: __________________________

Health insurance group number: ___________________________

If you are not the primary insurance holder, what is the FULL NAME of the health insurance policy holder? ________________________________

Primary Insurance Holder Birthdate: __________________________

Social Security Number of the primary card holder: __________________________

What is the CoPay amount for a specialist office visit? ______________

Name of your Secondary Insurance Company: ____________________________________
Address: ____________________________ Phone: ________________________
____
____

Health insurance policy number: __________________________

Health insurance group number: ___________________________

If you are not the primary insurance holder, what is the FULL NAME of the health insurance policy holder? ________________________________

Primary Insurance Holder Birthdate: __________________________

Social Security Number of the primary card holder: __________________________

What is the CoPay amount for a specialist office visit? ______________
Who is your primary care physician? _____________________________
Phone: _______________________ Fax: __________________________

When did you last see your primary care physician? ___________________________________

Please list any other doctors who you rely on for your healthcare:
____
____

What pharmacy do you use (Name and Location): _________________________________
____
____
Phone: _________________________________

Name / Address / Phone Number of your emergency contact:
____
____
____
____

Relationship: Spouse Partner Child Relative Friend Other

What is the reason for your visit today?
____
____

Your height: ___________ Weight: ___________

Do you smoke (Please Circle One):
Never Smoked Yes, I smoke No Socially
Recently Quit Quit Years Ago

Do you use chewing tobacco? Yes No
Do you drink alcoholic beverages? Daily Weekly Monthly Never
Do you use recreational drugs? Daily Weekly Monthly Never
If you use recreational druges, which drugs to you use?
I don't take drugs Pain Killers (not prescribed) Marijuana
Cocaine Meth Heroin Crack
Ecstasy Uppers Downers

Please tell us about YOUR medical history (Circle all that Apply):

None | Alzheimer's | Asthma / Lung Disease | Back / Neck Pain
Cancer | Chest Pain / Heart Attack | Chronic Skin Infection | Clotting Disorders
Congestive Heart Failure | Depression | Diabetes: Type 1 or Type 2 | Fibromyalgia
Gout | Hepatitis | High Blood Pressure | HIV / AIDS
Kidney Disease | Liver Disease | Osteoporosis | Parkinson's
Phlebitis | Stroke / TIA | Tuberculosis | Vascular Disease | Unexplained Weight Loss

List any other medical problems you may have: ____________________________________

____

What is your FAMILY medical history (Circle all that apply)?

Cancer Diabetes Heart Attack Stroke

Allergies:

No Known Allergies Penicillins Sulfa Drugs Anesthesia
Iodine Shell Fish Nuts
Other Allergies: ____________________________________

Describe what happens when you take medication that you are allergic to:

Blistering Fever Get Flushed Hives
Itch / Scratch Nausea Vomiting Rash
Fatigue Shortness of Breath

Please list your current medications: ____

____

Are you pregnant or is there a chance you could be: Yes No

To the best of my knowledge, the above information is correct. I, the above responsible party, hereby give my permission to El Paso Feet, Spa915, Southwest Laser Care and it's physicians to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition.

______________________________ ______________________________
Name Date

____
Signature

______________________________ ______________________________
Physician's Signature Date