ALL CARE FOOT CENTER - NEW PATIENT FORM **PLEASE PRINT**

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home # (___) _____ Cell # (___) _____ Work # (___) _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

E-Mail: _____

Family Physician: _____ Phone Number: (___) _____

Fax Number: (___) _____

Birth Date: ___/___/___ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: _____ Employer Address: _____

__FULL TIME__PART TIME __NOT EMPLOYED __SELF-EMPOYED__RETIRED __ACTIVE MILITARY DUTY __STUDENT

Pharmacy: _____ Pharmacy Phone Number: (___) _____

HOW DID YOU HEAR ABOUT US: **Doctor Referral** ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by: _____ Other: _____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name Phone Number Relationship

_____

_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, herby authorize _____ to pay and hereby assign directly to ALL CARE FOOT CENTER all benefits. I further acknowledge that any insurance benefits, when received by and paid to ALL CARE FOOT CENTER will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date**: _____

SOCIAL HISTORY

Do or Did you smoke cigarettes? ☐Yes ☐No If Yes, packs per day? _____ Stop date: _____

Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No

Allergies to any medication? ☐Yes ☐No If Yes, which medications? _____

Place of Birth? _____ Unusual Occupational Exposures? _____

Please list ALL medications you are currently taking: _____

_____

_____

ALL CARE FOOT CENTER - NEW PATIENT FORM **PLEASE PRINT**

MEDICAL HISTORY:

Previous Surgery/Hospitalizations _____

_____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			**Diabetes**		
Dizziness			**High Blood Pressure**		
Fainting Spells/Blackouts			**High Cholesterol**		
Eye Disease/Glaucoma/Cataracts			**Joint Pains/Swelling**		
Double Vision			**Swelling of ____Feet _____Ankles**		
Recent Vision Impairment			**Numbness/Tingling of hand/Feet**		
Impaired Hearing			**Color Changes in the Hands**		
Ringing in the Ears			**Chest Pressure/Chest Pain**		
Dryness of _____Eyes _____Mouth			**Chronic Back Pain**		
Recent Hair Loss			**Chronic Neck Pain**		
Asthma			**Parkinsonism**		
Recurrent Fever			**Osteoporosis**		
Thyroid Disorder			**Sciatica**		
Pneumonia			**Anemia or Blood Disorder**		
Pleurisy			**Skin Rash**		
Frequent Cough			**Psoriasis**		
Tuberculosis Exposure			**Recent Weight ____Gain _____ Loss**		
Difficulty Breathing			**Loss of Appetite**		
Coughing Up Blood			**Constant Thirst or Hunger**		
Rheumatic Fever			**Stomach/Duodenal Ulcer**		
Difficulty Urinating			**Abdominal Pain/Heart Burn**		
Painful/frequent Urination			**Frequent Nausea/Vomiting**		
Blood in Urine			**Heart Murmur**		
Nighttime Urination _____Times			**Cancer**		
Prostate Disorder			**Palpitations**		
Recurring Bladder Infections			**Convulsions OR Epilepsy**		
Kidney Disease/Stones			**Hepatitis/Jaundice**		
Pancreatitis			**HIV Virus Positive**		
Diverticulitis			**Chronic Anxiety**		
Phlebitis			**Depression**		
Insomnia					

Date of: Most Recent Medical Exam _____

EKG _____ Blood Tests _____ Chest X-Ray _____

Reason for office visit today: _____

_____