BAY AREA FOOT & LASER PODIATRY GROUP

PATIENT INFORMATION

Name _____ **Gender** [ ] M [ ] F [ ] Other **Age** _____

Date of Birth _____ **Height** _____ **Weight** _____ **Shoe Size** _____

Address _____ **City** _____ **Zip** _____

Contact Phone Numbers: ***Consent to leave a message and/or send texts? If yes, please check the box next to the number.***

[ ] **Home** _____ [ ] **Cell** _____ [ ] **Work** _____

Email _____ **Social Security Number** _____

Reason for Visit *(Check all that apply)* [ ] Foot/Ankle Pain [ ] Toenail Fungus [ ] Ingrown Nail [ ] Orthotics [ ] Routine Foot Care

Other _____

Race [ ] Causcasian [ ] American Indian/Alaskan Native [ ] Black/African American [ ] Asian/Native Hawaiian/Other Pacific

Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic/Latino

Occupation/Work _____ **Employer** _____

Marital Status _____

Emergency Contact Name _____ **Relationship** _____

Emergency Contact Number _____

INSURANCE INFORMATION *(Skip if you provided us insurance cards.)*

Primary Insurance Co _____ **ID #** _____ **Group #** _____

Secondary Insurance Co _____ **ID #** _____ **Group #** _____

If you have an HMO, were you referred to us by one of your doctors? [ ] Yes [ ] No

Primary Insurance Subscriber [ ] Self [ ] Parent/Guardian [ ] Spouse/Domestic Partner

Subscriber Name *(if different from patient)* _____ **Date of Birth** _____

Address *(if different from patient)* _____

Phone Number *(if different from patient)* _____

Primary Care Doctor _____

Date Last Seen _____ **Phone Number** _____

Who may we thank for referring you to our office? *(if different from PCP)* _____

Pharmacy Name _____ **Phone Number** _____

Pharmacy Address _____

PATIENT HISTORY

DRUG ALLERGIES	YES	NO
Local Anesthetics	[ ]	[ ]
Cortisone	[ ]	[ ]
Penicillin	[ ]	[ ]

Other _____

ARE YOU BEING TREATED FOR:	YES	NO
High Blood Pressure	[ ]	[ ]
Diabetes	[ ]	[ ]
Arthritis	[ ]	[ ]

Other _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? *(Check if YES)*

[ ] Abnormal Bleeding
[ ] Acid Reflux
[ ] Anemia
[ ] Arthritis
[ ] Asthma
[ ] Back Trouble
[ ] Bladder Infections
[ ] Blood Clots
[ ] Blood Transfusions
[ ] Bronchitis/Emphysema
[ ] Cancer
[ ] Diabetes
[ ] Fibromyalgia
[ ] Gout
[ ] Heart Attack
[ ] Heart Disease/Failure
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney Disease
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Migraine Headaches
[ ] Mitral Valve Prolapse
[ ] Neuropathy
[ ] Open Sores
[ ] Pneumonia
[ ] Polio
[ ] Rheumatic
[ ] Sickle Cell
[ ] Skin Disorder
[ ] Sleep Apnea
[ ] Stomach Ulcers
[ ] Stroke
[ ] Thyroid Disease
[ ] Tuberculosis

SOCIAL HISTORY

Tobacco Use: [ ] Never
[ ] Former
[ ] Sometimes
[ ] Every day

ALL PRESCRIBED MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, AND VITAMINS YOU ARE CURRENTLY TAKING

(If you have a list, we can make a copy.)

Medication Name	Dosage	Frequency Taken

ALL PRIOR SURGERIES

Name/Type of Surgery	Date

I hereby give my permission to Jonathan Huey, D.P.M. and/or Lisa Harrison, D.P.M. to administer and treat with such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I understand that I am solely responsible for any debts not covered by my health insurance.

Patient or Parent/Guardian Signature _____ **Date** _____