Montgomery Foot Care Specialists

NEW PATIENT FORMS

Social Security#:_____

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Cell Carrier _____

Phone: _____ Would like to receive text notifications? Y _____ N _____

Email: _____ Marital Status: S_____ D_____ M_____ W_____

Patient Employment: _____ Gender: M_____ F_____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work: _____

Whom may we thank for referring you: _____

Insurance

Who is responsible for this account: _____ Relationship to patient: _____

Resp. Party DOB/SS#: _____ _____ Phone Number: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy/Contract Number: _____ Policy/Contract Number: _____

Group Number: _____ Group Number: _____

Race: _____ Language: _____ Ethnicity: Hispanic or Non-Hispanic

Primary Care Physician: _____ Last Seen: _____

Endocrinologist: _____ Last Seen: _____

Dermatologist: _____ Heart/Vascular Doctor: _____

Medications

(Please list all milligrams & how taken. If you have a list please provide)

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____ Phone Number: _____

Allergies

(Please check all that apply and list) NONE: _____

	Anesthetics		Penicillin		Tape
	Drugs: _____		Sulfa		Novocain

	Foods: _____		Latex		Other: _____

Surgical History

_____

_____

_____

PERSONAL MEDICAL HISTORY

(Check all that apply)

	Frequent Headache / Migraines		High Blood Pressure		Hemophilia		Ankle Pain
	Kidney Disease		Arthritis		Hepatitis / Jaundice		Athlete's Pain
	Fainting		Psychiatric Treatment		Liver Disease		Bunion
	Tuberculosis		Asthma / Hay Fever / Shortness		Low Blood Pressure		Corn
	Emphysema		Sexually Transmitted Disease		Radiation Treatment		Callus
	Heart Trouble		AIDS / HIV		Rash		Foot and Leg Cramps
	Stroke		Artificial Heart Valves or Joints		Swollen Neck Glands		Flat Feet
	Neuropathy		Back Problem		Stomach Disorders / Ulcers		Heel Pain
	DVT (Blood Clots)		Bleeding Disorders		Blood Thinners: _____		Ingrown Nails
	Anemia / Blood Disorders		Cancer		Varicose Veins		Plantar Fasciitis
	Drug / Alcohol Abuse		Chest Pain on Mild Exertion		Weight Loss, unexplained		Plantar Warts
	Epilepsy / Seizures		Circulatory Problems		Thyroid / Parathyroid Disease		Tired Feet
	Ear / Nose / Throat Problem		Dialysis M W F OR T TH SA		Swelling in feet / legs		Other: _____
	Eye Trouble		Diabetes- HA1C: _____ avg. blood sugar: _____		Foot Ulcers		

What foot complaints do you have? (Include date and place of injury if applicable) _____

_____

_____

Has an immediate family member had any of the following (please indicate relationship) (i.e. mother, father, grandparents, siblings or children)

Cancer: _____ DVT (Blood Clots): _____

Diabetes: _____ Mental / Emotional Disorders: _____

Heart Trouble: _____ Arthritis: _____

High Blood Pressure: _____

Are parents still living? Yes or No If not, cause of death? _____

Health Review

(Circle any symptoms you have had in the past 3 months)

General	Fever Chills Fatigue Weight loss Weight gain
Head	Headache Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of legs Other
Hematology	Anemia Abnormal bleeding/bruising Blood Clots Other blood disorders
Respiratory	Persistent Cough Wheezing Shortness of Breath

Gastrointestinal	Difficulty swallowing Indigestion/Heartburn Abdominal Pain Change in bowls
Urinary	Painful Urination Frequent nighttime urination Bladder leaking Other: _____
Musculoskeletal	Joint pain/swelling/stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin textures Excessive thirst

Authorization

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any changes in my medical condition, I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Print: _____