NEW PATIENT FORM

** PLEASE COMPLETE ALL INFORMATION*

Date: ___________________ **Major Complaint:** ____

Have you seen a Podiatrist? _________ **Name of Podiatric Group:** ______________________________

DEMOGRAPHIC INFORMATION

NAME: First: ____________________________ **MI:** ________ **Last:** ______________________________

Date of Birth: ________________________________ **Gender:** □ Male □ Female

Ethnicity: _________________________________ Preferred Language: ______________________________

Social Security #: _________________________________

Address: ____

City: __________________________________ State: ______________ Zip: ______________________

□ Retired □ Student □ Employed Employer: ____

Home #: _____________________ Work #: _______________________ Cell #: ______________________

EMAIL Address: ____

How do you prefer to be contacted? □ E-mail □ Mail

Emergency Contact: __________________ Emergency Phone #:______________ Relationship: __________

INSURANCE INFORMATION

Primary Insurance: _________________________ Secondary Insurance: _________________________

Primary Card Holder: ______________________ Secondary Card Holder: ______________________

Card Holder DOB: ________________________ Card Holder DOB: ___________________________

Member #: _______________________________ Member #: _________________________________

Group #: ________________________________ Group #: ____________________________________

PRIMARY CARE INFORMATION

Primary Care Doctor (Who provides your health care): ____

Office #: _________________________________ Date of the last visit: ___________________________

MICSELLANEOUS

How did you hear about us? □ Friend □ Family □ Internet □ Referring MD □ Other: _____________

Primary Pharmacy: Name: ______________________________ Zip: __________ Phone: ______________

MEDICAL/SOCIAL HEALTH INFORMATION

- **Tobacco/Smoker: Smoker Current ________, Current Everyday ________,**
- **Current Some Days ________, Former________, Never________**
- **Alcohol: Y______ N______ # per day______**

Please list illnesses of diseases of mother, father, and siblings:

Mother: Deceased/Alive:______________________________

Father: Deceased/Alive:______________________________

Brother/Sister: Deceased/Alive:______________________________

Please list details and dates of all operations and injures:______________________________

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Please list all Allergies (include any drug allergies):______________________________

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____

Please list all medications that you are currently taking:______________________________

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____

Please circle any illness that may pertain to you:

MAJOR DISEASE

Diabetes
Hypertension
Angina
Heart Disease
Heart Attack
Murmur
Mitral Valve Prolapsed
Stroke
Chest Pain

HEENT

Headaches
Hearing Problems

GASTROENTESTINAL

Ulcers
Stomach Problems
Hiatal Hernia
Bowel Disorders
GI or Rectal Bleeding
Acid Reflux

VASCULAR

Anemia
Sickle Cell
Bleeding Disorders
Poor Circulation
Night Cramps
Leg Pain w/walking
Vein Problems
Spider Veins
Varicose Veins
Swelling Phlebitis
Leg Ulcerations
Blood Clots
Transfusions

PSYCHOLOGICAL

Anxiety
Depression
Psychiatric Conditions
Drug Dependency
Alcohol Dependency

RESPIRATORY

Asthma
Bronchitis
Frequent Colds
Lung Disease
Shortness of Breath
Tuberculosis
Emphysema

MISC

Epilepsy
Thyroid
Muscle Disease
Kidney Disease
Bladder Disease
Prostate Problems
Venereal Disease

SKIN CONDITIONS

____

CANCER HISTORY

____

ARTHRITIS

Osteoarthritis, Gout, Sero-negative, Reiter's Anklyosing, Spondylitis, Irritable Bowel Syndrome, Rheumatoid Arthritis

I hereby give permission to Dr. Jeremy M. Thomas and associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of the extremity condition. I also, herby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care.

______________________________ ______________________________

Signature of Patient / Guardian Date