ALABAMA FAMILY FOOT CLINIC

NEW PATIENT INFORMATION

PATIENT NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____CELL PHONE:_____

AGE:_____ DOB:_____SEX:_____ S.S#:_____RACE:_____

PLACE OF EMPLOYEMENT :_____

ETHNICITY: HISPANIC/ LATINO OR NON-HISPANIC/ NON-LATINO

PRIMARY DOCTOR:_____OFFICE PHONE:_____

NAME OF SPOUSE:_____ SPOUSE DATE OF BIRTH:_____

SPOUSE PHONE NUMBER:_____ SPOUSE SOCIAL (IF INSURED):_____

EMERGENCY CONTACT: NAME_____ PHONE:_____

INSURANCE INFORMATION (SKIP IF CARDS ARE PROVIDED)

PRIMARY INSURANCE:_____

GROUP#_____CONTRACT#_____

NAME OF INSURED:_____RELATIONSHIP TO PATIENT:_____

MALE/ FEMALE BIRTHDATE OF INSURED:_____

SECONDARY INSURANCE:_____

GROUP#_____CONTRACT#_____

NAME OF INSURED:_____RELATIONSHIP TO PATIENT:_____

MALE/ FEMALE BIRTHDATE OF INSURED:_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am fully responsible for any and all reasonable attorney fees, collection cost, interest and court cost associated with the collecting of any unpaid balance.

SIGNATURE:_____

I authorize Alabama Family Foot Clinic, P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office order. I request that payment from my insurance company be made directly to Alabama Family Foot Clinic, P.C. or to the party whom accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

SIGNATURE:_____

WHAT IS YOUR CHIEF COMPLAINT FOR THIS VISIT?_____

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE? YES OR NO WHEN?_____

FAMILY HISTORY (CANCER, DIABETES, HEART DISEASE): _____

DO YOU USE ANY FORM OF TOBACCO? YES OR NO HOW MUCH TOBACCO DO YOU USE?_____

ARE YOU WILLING TO QUIT TOBACCO? YES OR NO ARE YOU A FORMER TOBACCO USER?_____

ARE YOU CURRENTLY ON HOSPICE? YES OR NO

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

_____AIDS/ HIV	_____CHEST PAIN	_____KIDNEY PROBLEMS
_____LIVER DISEASE	_____ALZHEIMERS	_____COPD
_____LUPUS	_____ANEMIA	_____DEPRESSION
_____MULTIPLE SCLEROSIS	_____ARTHRITIS	_____DIABETES
_____OSTEOPOROSIS	_____ARTIFICIAL JOINT	_____EAR PROBLEMS
_____PACEMAKER	_____PHLEBITIS	_____BACK PROBLEMS
_____EPILEPSY	_____RADIATION TREATMENT	_____BLEEDING DISORDER
_____FAINTING	_____STROKE	_____CANCER
_____GOUT	_____THYROID DISORDER	_____CHEMICAL DEPENDENCY
_____HEADACHES	_____ULCERS	_____CHRONIC HEART DISEASE
_____HEMOPHILIA	_____VARICOSE VEINS	_____CIRCULATORY PROBLEMS
_____HYPERTENSION	_____OTHER: _____	

DRUG ALLERGIES:

_____ADHESIVE/TAPE	_____DEMEROL	_____PENICILLIN
_____ANTICOAGULANT THERAPY	_____IODINE	_____SEAFOODS
_____ASPIRIN	_____LATEX	_____SULFA
_____CODEINE	_____LOCAL ANESTHETICS	

OTHER ALLERGIES:_____

CURRENT MEDICATIONS OR PROVIDE LIST: _____

_____

PAST SURGERIES:_____

Pharmacy YOU USE:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND OR/ TREATMENT OF MY CONDITION.

SIGNATURE _____ **DATE**_____