

General Information:

Name _____ Age _____ Date of Birth _____

Address _____ Zip Code _____ Social Security# _____

Home phone _____ Work phone _____ Cell Phone _____

Parent/Guardian (if minor) _____ Spouse's name _____

Employer (self) _____ Work phone _____

Spouse Employer _____ Spouse SS#: _____ Spouse Work Phone _____

Party responsible for payment _____ **Family Physician** _____

Has a family member been a patient in this office? _____ Name _____

How did you hear about our office? _____ Friend _____ Phonebook _____ Sign _____ Doctor

Other _____

What is your present foot problem? _____

Health Information:

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Are you now, or have you been, under the care of a physician during the past 2 years? | Yes | No |
| 3. Have you experienced any ill effects from Novacaine, Penicillin or any other drugs? | Yes | No |
| 4. Do you have any allergies? | Yes | No |
| 5. Are you pregnant or plan to be in the near future? | Yes | No |
| 6. Have you had any serious illnesses or operations? | Yes | No |
| 7. Have you had any injuries or operations on your feet or legs? | Yes | No |

Have you ever been treated for any of the following?

- | | | |
|---------------------------|-----------------------|--------------------|
| Diabetes _____ | Blood Disorder _____ | Anemia _____ |
| Heart Trouble _____ | Rheumatic Fever _____ | Arthritis _____ |
| High Blood Pressure _____ | Kidney Ailment _____ | Epilepsy _____ |
| Asthma _____ | Liver Ailment _____ | Stroke _____ |
| Gout _____ | Cancer/Tumors _____ | Foot Surgery _____ |
| Phlebitis _____ | Stomach Ulcers _____ | AIDS _____ |

What medications are you presently taking? _____

Are you allergic to any medications? (example – Penicillin, Novacaine, Adhesive tape, etc.) _____

Is there any other information about your health that should be known? Yes No

Date _____ *Signature* _____

Insurance Information: (Please give your insurance card to the receptionist)

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Dr. Bruce G. Fawcett or any supplier for services rendered to me.

Date _____ *Signature* _____