New York Foot Center

WELCOME TO OUR OFFICE
Patient Information (Please Print)

Name ____ **Date of Birth** _____________________

Address ________________________________**Apt#**_____ **City**__________**State**______ **Zip**_______

Home Phone _____________________________ **Cell Phone** _______________________________

Email Address ____

Social Security _______________________ **Referred By** __________________________________

Employed By _______________________ **Business Phone** _________________________________

Family Physician __________________________ **Address**__________________________________

Date Last Seen _______________ **Dr's Phone Number** ____________________________________

Insurance Carrier __________________________ **I.D #** ____________________________________

Medicare # _______________________ **Secondary Carrier** _________________________________

What is the main problem for which you came to be treated?

____

Are you taking any medications or drugs at this time? Please include vitamins, over- the -counter and prescripton. ____

____

Is there any personal or family history of Diabetes? yes ______ no ______

Do you have any of the following?

Heart Problem	**yes____ no___**	**Asthma**	**yes ___ no ___**
Ulcers	**yes____ no___**	**Epilepsy**	**yes____ no___**
High Cholesterol	**yes____ no___**	**Arthritis**	**yes____ no___**
Phlebitis	**yes____ no___**	**Cancer**	**yes____ no___**
Rheumatic Fever	**yes____ no___**	**Kidney Problems**	**yes____ no___**
High Blood Pressure	**yes____ no___**	**Liver Problem**	**yes____ no___**

Are you subject to bleeding disorders? yes____ no___
Do you smoke cigarettes ? yes____ no___
Have you had any major surgeries? yes____ no___ What kind? ______________________________

Are you allergic to :

Local Anesthetics	**yes___ no___**	**Penicillin**	**yes___ no___**
Aspirin	**yes___ no___**	**Adhesive tape**	**yes___ no___**
Seafoods	**yes___ no___**	**Others**	**yes___ no___**

If so, please explain ____

Signature ____