



Mineola Foot Care, PC & Country Foot Care, PC

PATIENT INFORMATION

(MUST BE FILLED OUT COMPLETELY BY ALL PATIENTS)

Patient Name: _____

Patient Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone#: _____ Work #: _____

Date of Birth: _____ Social Security #: _____ Sex (circle one): Male Female

Occupation: _____ Marital Status (circle one): S / M / D / W

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Physician: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Phone #: _____ Physician Fax#: _____

Pharmacy Name: _____

Pharmacy Phone #: _____ Pharmacy Fax#: _____

Pharmacy Address: _____

How were you referred to the office? _____

INSURANCE INFORMATION

(MUST BE FILLED OUT COMPLETELY BY ALL PATIENTS)

Primary Insurance: _____ Policy ID#: _____ Group #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Policy Holder Social Security#: _____ Policy Holder Sex (circle one): M F

Relationship to Patient: Self / Spouse / Parent / Guardian / Domestic Partner

Secondary Insurance: _____ Policy ID#: _____ Group #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Policy Holder Social Security#: _____ Policy Holder Sex (circle one): M F

Relationship to Patient: Self / Spouse / Parent / Guardian / Domestic Partner



MEDICAL STATUS & HISTORY

(PLEASE CIRCLE ALL THAT APPLY)

- | | | |
|---------------------|----------------------|------------------|
| Diabetes | Varicose Veins | Cancer |
| Heart Condition | Drug Reactions | Tumors / Growths |
| High Blood Pressure | Arthritis | Pregnant |
| Kidney Disease | Circulation Problems | Other: _____ |
| Lung Disease | Recent Surgery | _____ |
| Liver Disease | HIV/AIDS | _____ |

ALLERGIES

(PLEASE CIRCLE ALL THAT APPLY)

- | | | | |
|-------------------|---------------|-------------|-------------|
| Penicillin | Adhesive Tape | Aspirin | Other _____ |
| Codeine | Latex | Antibiotics | _____ |
| Local Anesthetics | Narcotics | Sulfa | _____ |

MEDICATIONS

(PLEASE LIST ALL CURRENT MEDICATIONS)

FOOT COMPLAINT

(PLEASE LET US KNOW WHAT HURTS AND FOR HOW LONG)

I certify that the above information is true and correct to the best of my knowledge and that I have read and understand the Notice of Privacy Practices. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my feet.

Patient or Guardian Signature

Today's Date