town square
FAMILY FOOT CARE

Today's Date:_____

Patient's Name (First MI Last): _____

Patient's Date of Birth: _____Preferred Name/Nickname:_____

Gender: _____ Home/Cell Phone: _____

Patient's Street Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

From time to time we communicate with patients by Email and Text messages for appointment reminders and messages. You may opt out of these messages at any time. Check here to opt out now ☐

Parent's name (Legal Representative, for minor): _____

Family/Primary Physician: _____ Date last seen: _____

Did your Family Physician refer you to our clinic? Yes_____ No_____

If referred by another doctor/provider, whom? _____

How did you hear about our clinic?_____

Emergency Contact: _____ Phone: _____

→ We will need to photocopy your insurance card(s).

Primary Insurance Holder's Name: _____ Date of birth:_____

Relationship to patient: _____ Phone:_____

Your Pharmacy (name and location):_____

Shoe size:_____ Width:_____ Are you a current tobacco user: Yes:____ No:____

Patient's Name:_____ Date of Birth:_____

Why are you seeing the doctor today? _____

_____

→ Is this work-related? Yes_____ No_____

List all medical conditions. Check all that apply.

__Diabetes Type I
__Diabetes Type II
__Arthritis
__Asthma
__Anemia
__Gout
__Stroke
__High Blood Pressure
__Fainting

__Heart:_____
__Kidney:_____
__Cancer:_____
__Stomach:_____
__Circulatory:_____
__Thyroid:_____
__Liver:_____
__Nervous disorders:_____
__Other(s):_____

_____

Current Medications: List all medications you are presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route (oral, sublingual, subcutaneous injections, and/or topical):

Medication name _____ Dose _____ Frequency _____

_____

_____

_____

_____

_____

_____

List allergies to medications or tape: _____

_____

List any past surgeries you've had and year of procedure: _____

_____

_____

_____

List the medical conditions of your mother and father:

Mother:_____

Father:_____