

PATIENT INFORMATION FOR DR. CAWTHON:

DATE:

NAME: LAST _____, FIRST _____ MI _____,

ADDRESS: STREET _____

CITY/STATE _____, ZIP _____

PHONE #:(____)____-____, Do you have a second phone # (work, cell, etc.)(____)____-____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOW DID YOU HEAR ABOUT US? _____

IF REFERRED BY SOMEONE (FRIEND, DOCTOR, ETC.) _____

WHO IS THAT PERSON? _____

Emergency contact: Name _____ Relationship _____

Phone #: _____

INSURANCE INFORMATION:	
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Name of insured: _____ Relationship to you: _____

DOB of insured: _____, Social Security # of insured _____

Name of Insurance Co. _____ Policy # _____

Name of insured: _____ Relationship to you: _____

DOB of insured: _____, Social Security # of insured _____

Name of Insurance Co. _____ Policy # _____

WORK: Employed by _____

Work address: _____

Work phone: _____ Type of work: _____

**** RECENT HIPPA LAWS REQUIRE THAT WE ASK THE FOLLOWING: ****

Should medical records need to be released, who may we release these records to?

my insurance company another doctor's office employer other: _____

any of the above

Note: If this block is not signed, you must come by the office and sign a release before records can be sent.

Will you allow a family member (spouse/child/etc.) to pick up these records if you are unable to come by the office? YES NO

Signature: _____ **Date:** _____

Often times we call the patient to remind the patient of the patient's appointment. If we call your home to remind you of your appointment, or to leave a message, whom can we leave the message with? *If nothing is checked, we will not call to remind you of your appointment.*

myself my spouse other: _____,

answering machine **anyone (or machine) who answers the phone at my residence**

Signature: _____ **Date:** _____

I certify that the above information is true and correct to the best of my knowledge. (Parent/Guardian if minor)

Patient's Signature: _____ **Date:** _____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------------|--|---------------------|--|-----------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or
Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral Vascular Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart | | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other: _____

Comments on the above _____

Surgeries in the last 10 years: _____

Hospitalizations, other than for the above surgeries, over the last 10 years:

Family Doctor

Date of Last Visit

Females:

- Do you take birth control pills? Yes No
 Is there a chance you could be pregnant? Yes No

If you have an advanced directive or living will, please provide a written copy for our records.

MEDICATIONS:

PHARMACY _____
 PHARMACY PHONE NUMBER _____

ALLERGIES:

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Anticoagulant | <input type="checkbox"/> Local Anesthetics |
| Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |

Other: _____

Consent: 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 deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature: _____

Date: _____