MADISON PODIATRY ASSOCIATES, P.C.

TODAY'S DATE: _______/_______/________ AGE_______ DOB_______________ GENDER: M_____F______

PATIENT NAME: ____

HOME ADDRESS: ____

CITY: ____ STATE ______________ ZIP: _____________

HOME PHONE #: (________) ________-__________ CELL PHONE #: (________) _______-_______________

MARITAL STATUS: ______SINGLE _____MARRIED _____ WIDOWED _____DIVORCED _____PARTNER

EMPLOYER: ____WORK PHONE #:_______________________

OCCUPATION____

E-MAIL- ____SOC. SEC #:_____________________________

PRIMARY LANGUAGE: ___________________________ ETHNICITY: ___________________________________

PRIMARY CARE DOCTOR NAME:____

ADDRESS: ____ PHONE _____________________

PHARMACY: ______________________ LOCATION: ____________________PHONE #: (____) ______-________

<u>INSURANCE INFORMATION</u>

POLICY HOLDER'S NAME: ____________________________ POLICY HOLDER'S DATE OF BIRTH: _____________

PRIMARY INSURANCE COMPANY NAME: ____

OTHER MEDICAL INSURANCES____

<u>PATIENT HISTORY</u>

ALLERGIES: [ ] NONE KNOWN

[ ] MEDICATION ALLERGIES ____

[ ] ANESTHESIA ALLERGIES ____

[ ] FOOD ALLERGIES ____

OTHER____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE FREQUENCY

<u>EMERGENCY CONTACT</u>::____PHONE___________________________

RELATIONSHIP____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] **ABNORMAL BLEEDING**	[ ] **CANCER**	[ ] **LIVER DISEASE**	[ ] **SKIN DISORDER**
[ ] **ACID REFLUX**	[ ] **DIABETES**	[ ] **LOW BLOOD PRESSURE**	[ ] **SLEEP APNEA**
[ ] **ANEMIA**	[ ] **FIBROMYALGIA**	[ ] **MIGRAINE HEADACHES**	[ ] **STOMACH ULCERS**
[ ] **ARTHRITIS**	[ ] **GOUT**	[ ] **MITRAL VALVE PROLAPSE**	[ ] **RHEUMATIC FEVER**
[ ] **ASTHMA**	[ ] **HEART ATTACK**	[ ] **NEUROPATHY**	[ ] **THYROID DISEASE**
[ ] **BACK TROUBLE**	[ ] **PNEUMONIA**	[ ] **OPEN SORES**	[ ] **TUBERCULOSIS**
[ ] **BLADDER INFECTIONS**	[ ] **HEPATITIS**	[ ] **HEART DISEASE/FAILURE**	[ ] **OSTEOPOROSIS**
[ ] **BLOOD CLOTS**	[ ] **HIV/AIDS**	{] **BRONCHITIS/EMPHYSEMA**	
[ ] **BLOOD TRANSFUSION**	[ ] **STROKE**	[ ] **HIGH BLOOD PRESSURE**	
[ ] **POLIO**	[ ] **KIDNEY DISEASE**	[ ] **SICKLE CELL DISEASE**	

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____

____

SOCIAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

ALCOHOL USE:_____TIMES PER WEEK RECREATIONAL DRUG USE:____________________________________

IF YOU ARE DIABETIC:

Last fasting blood sugar_______ Last A1c Test__________________ Shoe size:__________________

FOR MEDICAL STAFF ONLY:

FOOT EXAM: [ ] TRUE [ ] FALSE **BLOOD PRESSURE:_______________________________**
WEIGHT**:**_________________________ HEIGHT____

MADISON PODIATRY ASSOCIATES, P.C.

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

___Our Website ___ Internet ___Google____Yahoo____Bing_____Other ____Yellow Pages: ___Book___YP.COM

Referral From? _________ Family _____________ Friend ____________________ Doctor (name):________________

TREATMENT CONSENT

____I hereby give permission for Dr. Bruce Jacob, or ____ to treat my feet medically, surgically and/or orthopedically.

____ I hereby give permission as parent / legal guardian of __________________________________ ___________________ _______________ for Dr. Bruce Jacob, or _________________________________ to treat his/her feet medically, surgically and/or orthopedically.

NAME____

SIGNATURE____**DATE**_____________________