First Visit Intake Form

FAMILY FOOTCARE GROUP, LLP

Date _____

Dr. P. Atlas Dr. N. Condro Dr. G. Atlas Dr. E. Kaplan Dr. L. Rosenfeld Dr. M. Del Rosso Dr. L. Willson

Monticello • Liberty • Middletown • Monroe • Port Jervis • Callicoon

Please Print:

Patient (first, middle, last)_____ M / F Age___ Date of Birth_____

LOCAL Address_____ City_____ St____ Zip_____

I am here month of _____ To _____

Vacation or Away

Address_____ City_____ St____ Zip_____

I am there month of _____ To _____

Home Phone:_____ Work Phone_____ SS# _____

E-Mail Address _____ Cell # _____

Place of Employment_____ Marital Status-----S, M, W, D

Student Status: (Circle) Full / PT School Name_____ Have you notified insurance of college Attendance ?Y / N

****

If this visit is for an injury, was it due to an auto accident or job-related injury? Y / N

If yes, name and address of Insurance Carrier_____ Where did it occur?_____

When did it occur? _____ How did it occur?_____ Was employer notified? Y / N

****

Have you had previous foot treatment? If yes, please explain_____

_____

How did you hear about our services?_____

Medical Doctor:_____ Address:_____ Date of last visit_____

Pharmacy Name:_____ Address: _____ Tel _____

Do you allow Family Footcare Group, LLP to access your medication history online? Y / N Fax:_____

****

PAST OR PRESENT MEDICAL CONDITIONS-PLEASE CHECK IF YES

___Childhood diseases	___Osteo (aging) Arthritis	___High Blood Pressure	___Joint Replacement
___Stomach problems (Ulcers, Colitis)	___Rheumatoid Arthritis	___Low Blood Pressure	___Gout
___**Diabetes (Insulin or Non-Insulin)**	___Kidney Disease	___Asthma/Emphysema	___Heart Condition
___Rheumatic Fever	___Cancer	___Hepatitis	___Liver Disease
___Epilepsy	___Tuberculosis	___Blood Disorders	___Mitral Valve Prolapse (Heart Murmur)
___Coumadin or other blood thinners	___Fibromyalgia	___Lyme Disease	___Stroke
		___Thyroid Condition	___ Smoking, Present / Past / Never

Have you had previous surgery?_____ What Type_____

Do you have to be pre - medicated with antibiotics before having dental work done? Yes / No

Height: _____ Weight: _____ Blood Pressure: _____

ALLERGIES: CHECK ALL THOSE THAT APPLY:

___Penicillin ___Other Antibiotics___Cortisone___Aspirin___Dental Anesthesia___Other Medications___Iodine (Seafood) None Known _____

Latex _____ Bandaids _____ Tape _____ Other _____

Contact in case of emergency:_____ Phone #

****

IF THE PRIMARY INSURANCE CARD HOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent/Spouse name:_____ SS#_____ Date of Birth_____

Parent/Spouse Place of Employment_____

If other than patient, send statements to: (Name, Address, Phone #_____

_____

_____

****

FOR OFFICE USE ONLY

Chief Complaint _____

Onset, Duration & History _____

_____

Trauma _____ Medication _____

Social Hx: Alcohol Daily _____ Y / N Past or Current Drug Use Y / N

Family Hx: Diabetes ☐ Arthritis ☐ Cardiac ☐ other ☐

Psychiatric (orientation/mood) _____