

ABOUT FEET, LTD
BRIAN R. WRIGHT, D.P.M.

→ PATIENT INFORMATION ←

Name: _____ DOB: _____ SS#: _____
Address: _____ Zip: _____
Home Phone: _____ Alternate/Cell: _____
Employer/School: _____ Occupation: _____ Phone#: _____
Primary Care Physician: _____ Phone#: _____ Last Visit: _____
Sex: F M Shoe Size: _____ Height: _____ Weight: _____ Marital Status: S M D
Spouse: _____ DOB: _____ SS#: _____
Responsible Party: _____ DOB: _____ SS#: _____
Address: _____ Zip: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____

→ INSURANCE INFORMATION ← (IF INSURANCE IS THROUGH SPOUSE OR PARENT, PLEASE COMPLETE SECTION)

Name of Insured: _____ DOB: _____ SS #: _____

→ MEDICATIONS ← (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER, AND VITAMINS)

Pharmacy Name: _____ Phone: _____

→ ALLERGIES ←

→ MEDICAL HISTORY ← (PLEASE CIRCLE ALL THAT APPLY, IF NOT LISTED USE OTHER(S) SECTION)

AIDS/HIV	Back Problems	Diabetes (type I or II)	Hepatitis or Jaundice	Smoke (____ pack(s) per day)
Allergy to Anesthetics	Bleeding Disorders	Ear Problems	High/Low Blood Press	Stroke(s)
Allergies/Hay Fever	Cancer	Epilepsy	Kidney Problems	Swelling feet/ankles
Anemia	Chemical Dependency	Eye/vision Problems	Liver Disease	Tuberculosis
Angina	Chest Pain	Fainting	Numbness Feet/Legs	Ulcers
Arthritis	Chronic Diarrhea	Gout	Psychiatric Care	Other(s): _____
Artificial Valves/Joints	Circulatory Problems	Headaches	Respiratory Disease	_____
Asthma	Cramp feet/leg	Heart Disease	Skin Disorder	_____

DETAILS FOR ANY CONDITIONS MENTIONED ABOVE: _____

PAST SURGERIES (INCLUDING DATE(S) AND NAME OF SURGEON(S)): _____

What are you being seen for? _____
When did symptoms first occur? _____
How'd you hear about our office? _____