BATAVIA FOOT CARE CENTER
CONFIDENTIAL PATIENT INFORMATION FORM
(YOU MUST BE 18 YEARS OR OLDER TO SIGN)
PLEASE PRINT

____
(LAST NAME) (FIRST NAME) (MI)

SOC SEC NUMBER________________________ AGE________ DATE OF BIRTH________________

SINGLE MARRIED WIDOWED DIVORCED ______________________________________
(SPOUSE OR PARENT IF MINOR) SOC SEC NUMBER DATE OF BIRTH

ADDRESS______________________________ CITY________________ STATE_____ ZIP__________

PHONE: HOME__________________ CELL____________________ WORK____________________

EMAIL ADDRESS____________________ HEIGHT_____ WEIGHT______ SHOE SIZE______ WIDTH_____

____
OCCUPATION – PATIENT NAME & ADDRESS OF EMPLOYER

FAMILY PHYSICIAN____________________ ADDRESS___________________ LAST SEEN___________

PHARMACY____________________________ ADDRESS_____________________________________

FORMER PODIATRIST___________________________________ LAST SEEN___________________

DO YOU HAVE DIABETES? YES NO DATE OF LAST BLOOD SUGAR______________ A1C________

WHAT IS YOUR CHIEF FOOT COMPLAINT? ____

OPERATIONS (DATE & TYPE OF OPERATION)____

MEDICATIONS – PLEASE LIST BELOW OR PROVIDE A SEPARATE LIST

MEDICATION	DOSAGE	FREQUENCY

ANY FAMILY HISTORY OF: **(PLEASE CIRCLE THOSE THAT APPLY & WHICH RELATIVE HAS THE STATED DISEASE)**

DIABETES	**CANCER**	**HEART DISEASE**	**HIGH BLOOD PRESSURE**	**NONE**
Mother: Living / Deceased	Mother: Living / Deceased	Mother: Living / Deceased	Mother: Living / Deceased	
Father: Living / Deceased	Father: Living / Deceased	Father: Living / Deceased	Father: Living / Deceased	
Relative: ______________	Relative: ______________	Relative: ______________	Relative: ______________	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE THOSE THAT APPLY)

HEART TROUBLE * ANEMIA * CANCER * KIDNEY TROUBLE * HIGH BLOOD PRESSURE * ASTHMA * LIVER TROUBLE * ARTHRITIS

STOMACH ULCERS * VARICOSE VEINS * BROKEN BONES IN FOOT OR LEGS * CRAMPS OR NUMBNESS IN FEET OR LEGS **NONE**

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING: (PLEASE CIRCLE THOSE THAT APPLY)

PENICILLIN * NOVOCAINE * ANESTHETICS * BETADINE * CODEINE * ADHESIVE TAPE * SULFA **NONE**

OTHER DRUGS______________________FOODS___________________________MATERIALS__________________________

Does the staff of BFCC have your permission to communicate information regarding medications and/or appointments?
HOME ANSWERING MACHINE? YES NO WITH ANOTHER PERSON? YES NO CELL PHONE? YES NO
VIA E-MAIL/PORTAL? YES NO WORK ANSWERING MACHINE? YES NO MOBILE TEXT? YES NO

WHO MAY YOU AUTHORIZE US TO RELEASE/DISCUSS YOUR MEDICAL INFORMATION?
NAME_________________________ PHONE #_____________________ RELATIONSHIP:_______________
NAME_________________________ PHONE #_____________________ RELATIONSHIP:_______________

I HEREBY GIVE PERMISSION TO DR DAWN DRYDEN AND/OR DR ZERAH ALI TO EXAMINE AND TREAT MY FEET MEDICALLY, SURGICALLY OR ORTHOPEDICALLY.

XX____ DATE________________
SIGNATURE OF PATIENT OR REPRESENTATIVE

Printed name of representative (if applicable) ____________________________ Relationship: ______________