

**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 ASSOCIATES TO EXAMINE AND TREAT MY FEET MEDICALLY, SURGICALLY OR ORTHOPEDICALLY.**

XX \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PATIENT OR REPRESENTATIVE

Printed name of representative (if applicable) \_\_\_\_\_ Relationship: \_\_\_\_\_