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VALLEJO FOOT & ANKLE CLINIC
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NEW PATIENT INFORMATION RECORD

Patient Name _____ Date of Birth ___/___/___ Age _____ Sex: M F

Address _____ Telephone (_____) _____

City _____ Zip _____-_____ Social Security# _____-_____-_____

Occupation _____ Work or Cell # (_____) _____

E-mail Address: _____ Shoe Size: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Name of Spouse / Guardian _____ Phone # (_____) _____

Billing Information: (Please provide the receptionist with insurance cards for scanning)

Primary Insurance _____

Secondary Insurance _____

If other than patient, enter the name and address of person responsible for this account:

_____

Whom may we thank for referring you to us: _____

MEDICAL HISTORY

Primary Foot Complaint _____ For how long? _____

List of Medications: _____

Allergies to Medications: _____

Symptoms? (i.e., upset stomach, difficulty breathing) _____

Primary Physician _____ Date of last visit ___/___/_____

Former Podiatrist _____ Treatment for _____

Please circle if you have the following:

Y N Bunions	Y N Alcohol Abuse	Y N Gout
Y N Corn/Calluses	Y N Anemia	Y N Heart Disease
Y N Circulation Problems	Y N Arthritis	Y N High Blood Pressure
Y N Foot/Leg Cramps	Y N Blood Clotting	Y N Kidney Disease
Y N Foot/Leg Numbness	Y N Cancer	Y N Liver Disease
Y N Painful Toes	Y N Cigarette Use	Y N Lung Disease
Y N Toenail Problems	Y N Diabetes 1 or 2	Y N Stomach Ulcers

I hereby give Vallejo Foot & Ankle Clinic (VFAC) permission to render examination and treatment of my foot conditions. I request that payment of medical benefits be made to VFAC on my behalf for any services furnished to me. I authorize the release of medical information to those agents requesting any information needed to determine these benefits payable for related services. Furthermore, I realize that by signing this form, I agree to pay for any services rendered that are denied or not covered by my insurance company.

Signature _____ Date _____/_____/_____