Patient Information:

Last Name _____ First _____ MI _____ Male_____ Female_____

Date of Birth ____/____/____ Age ____ Social Security # _____ Drivers Lic #_____
Address: _____ City _____ Zip Code _____
Phone _____ Cell _____ Employer Phone_____
E-mail Address _____
Employer _____ Occupation _____
Child ____ Unmarried ____ Married ____ Divorced ____ Widowed ____ Domestic Partner ____ Other_____
Race _____ Ethnicity _____ Hispanic _____ Not Hispanic _____ Unknown/Declined
Pharmacy _____ Street _____ City _____
Primary Care Physician _____ City _____
Referred by _____

Responsible Party For Payment (If patient is a minor)

Last Name _____ First _____ MI _____ Relationship to Patient _____
Address _____ Phone _____
Employer _____ Employer Phone _____

Spouse's Last Name _____ First _____ MI_____ Male _____ Female_____
Address _____ Phone _____
Employer_____ Employer Phone _____

Insurance Information (Please present insurance cards to front desk)

Primary Insurance _____ Insured Name _____
Insured DOB _____ Insured SSN _____ Employer _____
Policy Number _____ Group Number _____Relationship to Patient _____

Secondary Insurance _____ Insured Name _____
Insured DOB _____ Insured SSN _____ Employer _____
Policy Number _____ Group Number _____Relationship to Patient _____

In Case of Emergency: (OTHER THAN LISTED ABOVE)

Name _____ Relationship _____
Address _____ Phone _____

I authorize any holder of medical information about any treatment or examination of myself/my child to release information to third party payors in order to determine benefits for services provided. I authorize payment by third party payors in order to determine benefits for services provided. I authorize payment by my third party payor directly to Sequoia Foot Care Group. I permit a copy of this authorization to be used as the original.

Signature: _____ Date _____

Sequoia Foot Care Group

Patient Medical History

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Check all your Present Medical Health Problems &
Check all Family Medical Health Problems that applies accordingly

Disease:	**Self**	**Mother**	**Father**	**Brother**	**Sister**
Diabetes					
Hypoglycemia					
Heart Problems					
HBP					
Stroke					
Seizures					
Lung Problems					
TB					
Sleep Apnea					
Liver Problems					
Kidney Problems					
Bladder Problems					
Prostate Problems					
Stomach Problems					
Bowel Problems					
Cancer					
Blood Clots or Bleeding Tendency					
Thyroid Problems					
Back Trouble					
Arthritis					
Mental Health Issues/Phobias					
Muscle Disorders					
Skin Disorders					
Neurological Disorders					
Anemia					
Dementia					
Anxiety					
GERD					
Glaucoma					
High Cholesterol					

List all Surgeries you have ever had in your lifetime:

_____

_____

_____

List any known Allergies you have:	Type of Reaction:

Do you have a Latex Allergy? _____

Are you currently taking a
Blood Thinner? _____

Are you Pregnant?
Or could you be? _____

Do you use Tobacco Products? _____
(If yes, how often?)
Do you drink Alcoholic Beverages? _____
(If yes, how often?)
Do you use Illicit Drugs? _____
(If yes, how often?)

_____ _____

Signed By: Patient/Parent/Guardian Date Signed

SEQUOIA FOOT CARE GROUP

MEDICATION LIST

Patient's Name: _____

Today's Date: _____

LIST YOUR CURRENT MEDICATIONS	STRENGTH (mg)	DIRECTIONS (How is this taken?)