

Sunrise Family Foot Care Center
10109 West Oakland Park Blvd
Sunrise, Florida 33351
Phone (954) 748-9444 Fax (954) 749-8712
drross@sunrisefamilyfootcare.com

WELCOME TO OUR OFFICE

Patient Name _____ Age _____ Sex _____ Date of Birth _____

Current Address _____ Home Phone() _____ Work Phone() _____

City _____ Zip _____ E-Mail _____

Ethnicity _____ Race _____ Preferred Language _____

Permanent Address _____ Phone () _____

City _____ State _____ Zip _____

Social Security No. _____ Driver's License No. _____

Marital Status _____ Spouse's Name _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to patient _____

Insured Date of Birth _____ Insured Social Security No. _____

Secondary Insurance _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to patient _____

Insured Date of Birth _____ Insured Social Security No. _____

Person responsible for account _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____

MEDICAL INFORMATION

Family Physician _____ Date of Last Exam _____

Address _____ Phone() _____

City _____ State _____ Zip _____

What medications are you presently taking or use on occasion (if any), including **prescription medications, over-the-counter medications** and **vitamins**?

Are you allergic to any MEDICATION you know of? _____

What Pharmacy would you like prescriptions sent to? (*Please indicate Pharmacy Name and Crossroads and/or Phone number if you have it*):

Are you being treated or have you been treated in the past for ANY of the following:

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> other G.I. Problems |
| | explain _____ |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Phlebitis- which leg? _____ | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer - Type? _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> other Heart Problems | <input type="checkbox"/> other Neuro-muscular problems |
| explain _____ | explain _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Tuberculosis | Smoking Status (Check One): |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Current Every Day Smoker |
| <input type="checkbox"/> other Respiratory problems | <input type="checkbox"/> Current Someday Smoker |
| explain _____ | <input type="checkbox"/> Former Smoker |
| | <input type="checkbox"/> Never Smoker |

Describe any operations or hospitalizations you have had and list dates. _____

What problems are you having with your legs or feet today? _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ SHOE SIZE _____ SHOE TYPE _____

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**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. Yes No

Do you want to be exempt from public reporting? Yes No

I consent to allow mail to be sent to the address on file. Yes No

May we call the phone number on file? Yes No

I consent to allow the office to leave me voicemails. Yes No

Will you allow internet based delivery reminders like email? Yes No

You may leave a message with the following person(s):
(please check all that apply)

Wife Husband Daughter Son

Other: _____

Print Patient Name

Date

Patient Signature

Parent, Guardian or Patient's legal representative
Signature