

**Fenton Foot Care Annual Update
Copy of Insurance Card & Photo Id must be presented**

Patient name _____ Patient's Date of Birth _____

Social Security Number: _____ Email: _____

Address _____
(Street) (City) (State) (Zip)

Primary phone number home: _____ Cell _____ Work _____

Your Height _____ Shoe size _____ Weight _____ Are you Diabetic Y / N

Primary Care/Family Doctor _____ Last Date Seen: _____

History

Smoker YES NO

Recent Medical Changes

Years Since Quit _____

List recent surgeries (within the last two years)

Packs Per Day _____

Alcohol Consumption _____

Allergies – Only Medications

Penicillin	YES	NO
Codeine	YES	NO
Sulfa	YES	NO
Latex	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Lidocaine	YES	NO
Tape	YES	NO
No Allergies	None	

Diagnosis/Change of Medical Condition (Condition & Date of Diagnosis/Change)

Other: _____

Hospitalizations (Date & reason of hospitalizations)

Medications – Please List Current Medication & Dosages

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give Fenton Foot Care permission to leave a message when contacting me about my medical care YES NO

I acknowledge that I was provided a copy of the Notice of Privacy Practices & Fenton Foot Care's Financial Agreement (Version 1/1/2012). I acknowledge that I have read (or had the opportunity to read if I so chose) these documents. I understand and agree to the terms stated within the documents. _____
Initial

Patient Signature/ Guardian Signature (if patient is a minor)

Date