First Visit Intake Form

Date ____________________

Dr. P. Atlas Dr. N. Condro Dr. G. Atlas Dr. E. Kaplan Dr. L. Rosenfeld Dr. C. Pham Dr. J. Berkovic
Monticello • Liberty • Middletown • Monroe • Port Jervis • Callicoon

Please Print:

Patient (first, middle, last)______________________ M / F Age____ Date of Birth__________
LOCAL Address______________________ City______________ St____ Zip______
I am here month of ____________ To ______________
Vacation or Away
Address______________________ City______________ St____ Zip______
I am there month of ____________ To ______________
Home Phone:______________ Work Phone______________ SS# ______________
E-Mail Address ______________ Cell # ______________
Place of Employment______________________ Marital Status-----S, M, W, D
Student Status: (Circle) Full / PT School Name______________ Have you notified insurance of college Attendance ?Y / N

****

If this visit is for an injury, was it due to an auto accident or job-related injury? Y / N
If yes, name and address of Insurance Carrier______________________ Where did it occur?______________
When did it occur? ________ How did it occur?______________________ Was employer notified? Y / N

****

Have you had previous foot treatment? If yes, please explain______________________
____
How did you hear about our services?______________________
Medical Doctor:______________ Address:______________ Date of last visit__________
Pharmacy Name:______________ Address:______________ Tel ______________
Do you allow Family Footcare Group, LLP to access your medication history online? Y / N Fax:______________

****

PAST OR PRESENT MEDICAL CONDITIONS-PLEASE CHECK IF **YES**

___Childhood diseases
___Stomach problems (Ulcers, Colitis)
___**Diabetes (Insulin or Non-Insulin)**
___Rheumatic Fever
___Epilepsy
___Coumadin or other blood thinners
___Osteo (aging) Arthritis
___Rheumatoid Arthritis
___Kidney Disease
___Cancer
___Tuberculosis
___Fibromyalgia
___High Blood Pressure
___Low Blood Pressure
___Asthma/Emphysema
___Hepatitis
___Blood Disorders
___Lyme Disease
___Thyroid Condition
___Joint Replacement
___Gout
___Heart Condition
___Liver Disease
___**Mitral Valve Prolapse (Heart Murmur)**
___Stroke
___Smoking, Present / Past / Never

Have you had previous surgery?______ What Type______________________

Do you have to be pre - medicated with antibiotics before having dental work done? Yes / No

Height: __________ Weight: __________ Blood Pressure: __________

ALLERGIES: CHECK ALL THOSE THAT APPLY:

___Penicillin ___Other Antibiotics ___Cortisone ___Aspirin ___Dental Anesthesia ___Other Medications ___Iodine (Seafood) None Known ____
Latex ________ Bandaids ________ Tape ________ Other ______________

Contact in case of emergency:______________ Phone # ______________

****

IF THE PRIMARY INSURANCE CARD HOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent/Spouse name:______________ SS#______________ Date of Birth__________
Parent/Spouse Place of Employment______________________
If other than patient, send statements to: (Name, Address, Phone #______________________
____
____

****

FOR OFFICE USE ONLY

Chief Complaint ______________________________
Onset, Duration & History ______________________________
____
Trauma ______________________ Medication ______________________
Social Hx: Alcohol Daily ________ Y / N Past or Current Drug Use Y / N
Family Hx: Diabetes ☐ Arthritis ☐ Cardiac ☐ other ☐
Psychiatric (orientation/mood) ______________________________