BAY AREA FOOT & LASER PODIATRY GROUP
A Professional Corporation

MARK E. WOLPA D.P.M.
JENNIFER BARLOW D.P.M.
TERESA VAN WOY D.P.M.

WELCOME!

PATIENT INFORMATION:

Patient's Name_____ Sex: M ( ) F ( )

Address_____ City_____ Zip_____

Telephone #_____ Cell Phone #_____ Age_____

Date of Birth _____Weight_____ Height_____ Shoe Size_____

Ethnicity:[ ] Hispanic/ Latino Race: [ ] American Indian/ Alaskan Native [ ] Black/African American
[ ] Not Hispanic/Latino [ ] Asian/Native Hawaiian/Other Pacific [ ] Caucasian

Marital Status _____ Social Security Number_____

Occupation_____ Employer_____
Work Work
Address_____Telephone_____

Email Address_____ Emergency Contact Name_____
Telephone #_____

PARENT OR SPOUSE INFORMATION:

Name_____ Date of Birth_____ Occupation _____

Employer _____ Work telephone _____

INSURANCE INFORMATION:

Name of Insurance Co._____ ID# _____Group#_____

AUTHORIZATION / REFERRAL # _____ CO-PAYMENT AMOUNT____

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

Name of you Primary Care Physician_____ Date last seen_____

Phone Number_____

Pharmacy Name_____ Phone Number_____

Address_____

PATIENT HISTORY:

ALLERGIES:	YES	NO
Local Anesthetics…….	____	____
Cortisone……..	____	____
Penicillin……..	____	____
Other_____		

ARE YOU BEING TREATED FOR:	YES	NO
High Blood Pressure……..	____	____
Diabetes…….	____	____
Arthritis……..	____	____
Other_____		

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS), If you have a list, we can make a copy:

NAME DOSE FREQUENCY

_____
_____
_____
_____
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] ABNORMAL BLEEDING
[ ] ACID REFLUX
[ ] ANEMIA
[ ] ARTHRITIS
[ ] ASTHMA
[ ] BACK TROUBLE
[ ] BLADDER INFECTIONS
[ ] BLOOD CLOTS
[ ] BLOOD TRANSFUSION
[ ] BRONCHITIS /EMPHYSEMA
[ ] CANCER
[ ] DIABETES
[ ] FIBROMYALGIA
[ ] GOUT
[ ] HEART ATTACK
[ ] HEART DISEASE/FAILURE
[ ] HEPATITIS
[ ] HIGH BLOOD PRESSURE
[ ] HIV/AIDS
[ ] KIDNEY DISEASE
[ ] LIVER DISEASE
[ ] LOW BLOOD PRESSURE
[ ] MIGRAINE HEADACHES
[ ] MITRAL VALVE PROLAPSE
[ ] NEUROPATHY
[ ] OPEN SORES
[ ] PNEUMONIA
[ ] POLIO
[ ] RHEUMATIC FEVER
[ ] SICKLE CELL DISEASE
[ ] SKIN DISORDER
[ ] SLEEP APNEA
[ ] STOMACH ULCERS
[ ] STROKE
[ ] THYROID DISEASE
[ ] TUBERCULOSIS

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY: DATE:

_____
_____

SOCIAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIMES [ ] EVERYDAY

I hereby give my permission to Mark E. Wolpa, D.P.M., Jennifer Barlow, D.P.M., or Teresa Van Woy, D.P.M. to administer and treat with such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I understand that I am solely responsible for any debts not covered by my health insurance.

TODAYS'S DATE: _____ SIGNATURE: _____

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 (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature