BAY AREA FOOT & LASER PODIATRY GROUP

A Professional Corporation

3000 Colby St #104
Berkeley, Ca 94705
(510) 849-3800

JONATHAN HUEY D.P.M.

106 La Casa Via #270
Walnut Creek, Ca 94598
(925) 937-2222

PATIENT INFORMATION

Name: ____ **Birth Sex:** M [ ] F [ ] **Age:** __________

Date of Birth: ____________________ **Height:**______________ **Weight**: ___________ **Shoe Size:** ________

Address: ____ **City:** ___________________ **Zip**: ___________

Contact Numbers: ***Consent to leave a message and/or send texts? If yes, please check box next to number***

[ ] Home: ______________________ [ ] Cell: ______________________ [ ] Work: ______________________

Email*:* ____ **Social Security Number:**______________________

Reason for Visit *(Check all that apply)* **:** [ ]Foot/Ankle Pain [ ] Toenail Fungus [ ] Ingrown Nail

[ ] Orthotics [ ] Routine Foot Care Other: ____

Race: [ ] Caucasian [ ] American Indian/Alaskan Native [ ] Black/African American

[ ] Asian/Native Hawaiian/Other Pacific **Ethnicity:** [ ] Hispanic/Latino [ ] Not Hispanic/Latino

Occupation/Work:______________________________ **Employer :**____________________________________

Marital Status: ______________________________

Emergency Contact Name: ______________________________ **Relationship:** __________________________

Emergency Contact Number: ___________________________________

INSURANCE INFORMATION *(skip if you provided us insurance cards)*

Primary Insurance Co: ____________________ **ID#:**____________________**Group#**:__________________

Secondary Insurance Co:____________________ **ID#:**____________________**Group#:**_________________

If you have an HMO were you referred to us by one of your doctors? [ ] Yes [ ] No

Primary Insurance Subscriber: [ ] Self [ ] Parent/Legal Guardian [ ] Spouse

Parent/Spouse Name: ____ **Date of Birth:** __________________

Subscriber Address *(if different from above):* ____

Subscriber Phone number (*if different from above):* _______________________

Primary Care Doctor: ____

Date Last Seen: ___________________________ **Phone Number:** ___________________________

Who may we thank for referring you to our office *(if different from PCP):* ______________________________

Pharmacy Name: ______________________________ **Pharmacy Phone Number:**_______________________

Pharmacy Address: ____

PLEASE TURN PAGE OVER

PATIENT HISTORY

DRUG ALLERGIES:	YES	NO
Local Anesthetics…..	[ ]	[ ]
Cortisone…............	[ ]	[ ]
Penicillin…............	[ ]	[ ]

Other:_______________________________

ARE YOU BEING TREATED FOR:	YES	NO
High Blood Pressure…...........................	[ ]	[ ]
Diabetes…...	[ ]	[ ]
Arthritis…...	[ ]	[ ]

Other: ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Check if YES)

[ ] Abnormal Bleeding
[ ] Acid Reflux
[ ] Anemia
[ ] Arthritis
[ ] Asthma
[ ] Back Trouble
[ ] Bladder Infections
[ ] Blood Clots
[ ] Blood Transfusions
[ ] 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
[ ] Sickle Cell
[ ] Skin Disorder
[ ] Sleep Apnea
[ ] Stomach Ulcers
[ ] Stroke
[ ] Thyroid Disease
[ ] Tuberculosis

SOCIAL HISTORY

Tobacco Use: [ ] Never
[ ] Former
[ ] Sometimes
[ ] Everyday

PLEASE LIST ALL PRESCRIBED MEDICATIONS/OVER THE COUNTER/ VITAMINS YOU ARE CURRENTLY TAKING

If you have a list we can make a copy

Medication Name	Dosage	Frequency taken

PLEASE LIST ALL PRIOR SURGERIES

Name/Type of Surgery	Date

I hereby give my permission to Jonathan Huey, 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.

Patient or Parent Signature: ____ Date:__________________________