Family Footcare Mark C. Baxter, DPM

Name _____ SSN # _____ - _____ - _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer_____ Work Phone_____ Marital Status_____

Spouses Name: _____Spouses Employer & Phone Number: _____

Responsible Party (If patient is a minor) _____ SSN _____ - _____ - _____

INSURANCE INFORMATION: ***Only fill out this section if you are not the subscriber***

Insurance _____ Subscriber's Name _____ Subscriber's Date of Birth ___/___/_____

Subscriber's Social Security Number _____ - _____ - _____ Subscriber's Employer _____

Whom May We Contact In Case Of An Emergency? _____ Phone_____

Nearest Relative Not Living With You _____ Phone _____

Family Physician _____ Phone _____

Pharmacy _____ Phone _____

YES NO (PLEASE CHECK)

___ ___ 1. I give permission to Family Footcare to leave messages on my answering machine.
___ ___ 2. I give permission to Family Footcare to discuss health information with immediate family.
___ ___ 3. I have access to Privacy Practices (HIPAA) in waiting area . ***RED FOLDER ON WALL***
___ ___ 4. I give Dr. Baxter permission to take photos of my feet only for medical purposes.

Family Footcare is now storing your health records electronically through IQ Health patient portal to more effectively manage your care. If you wish to participate, please provide your email so we can send you an email to set up your patient portal account, otherwise, please check no.

Yes: _____ Email: _____ No: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I DO HEREBY AUTHORIZE FAMILY FOOTCARE DR. BAXTER'S OFFICE TO PERMIT ANY INSURER PROVIDING ME OR MY DEPENDENTS UNDER THEIR CARE TO INSPECT THE MEDICAL RECORD IN CONNECTION WITH ANY CHARGES ARISING FROM MY TREATMENT IN THIS OFFICE. I FURTHER AUTHORIZE ANY SUCH INSURER TO PAY DIRECTLY TO FAMILY FOOTCARE DR. BAXTERS OFFICE ANY PAYMENTS FOR CHARGES ARISING FROM SERVICES TO ME.

SIGNATURE:_____ **DATE:**_____

PLEASE SEE BACKSIDE FOR ADDITIONAL QUESTIONS

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Health Conditions: (please check all current health conditions)

_____ Anemia	_____ COPD	_____ High Blood Pressure	_____ Seasonal Allergies
_____ Aneurysm	_____ Dementia	_____ Hyperthyroidism	_____ Seizure Disorder
_____ Anxiety	_____ Depression	_____Hypothyroidism	_____ Sleep Apnea
_____ Arthritis	_____ Diabetes	_____ Irritable Bowel	_____ Stroke
_____ Asthma	_____ Emphysema	_____ Kidney Disorder	_____ Tuberculosis
_____ Bleeding Disorder	_____ GERD	_____ Mental Illness	_____ Foot Ulcers
_____ Blood Clots	_____ Glaucoma	_____ Neuropathy	
_____ Bronchitis	_____ Gout	_____ Osteoporosis	
_____ Cancer	_____Heart Condition	_____ Peripheral Vascular Disease	
_____ Cholesterol	_____ HIV/AIDS/Hep.	_____ Prostate Disorder	

Provide any additional information or other health conditions not listed above:

_____

List all current prescription medications if you did not bring a list with you:

_____

_____

_____

List any medication allergies you have:_____

Social History: **Do you drink alcohol?** YES: (how much/often) _____ NO_____

Previous history of alcohol use: Age You Started _____ Age You Quit_____

Do you smoke? YES: (how much/how long) _____ NO_____

Previous smoker: Age You Started _____ Age You Quit_____

Family Health History: ***List current/past medical history of your family to the best of your knowledge***

Father's Health History:_____

Mother's Health History:_____

Immunizations:

Flu: Yes_____ No_____ If yes, When:_____

Pneumonia: Yes:_____ No:_____ If yes: When:_____