Sunrise Family Foot Care Center
10109 West Oakland Park Blvd
Sunrise, Florida 33351
Phone (954) 748-9444 Fax (954) 749-8712
drross@sunrisefamilyfootcare.com

WELCOME TO OUR OFFICE

Patient Name _____ Age_____ Sex_____ Date of Birth _____

Current Address_____ Home Phone( )_____Work Phone( )_____

City _____ Zip _____ E-Mail_____

Ethnicity_____ Race_____ Preferred Language_____

Permanent Address _____ Phone ( )_____

City _____ State _____ Zip _____

Social Security No. _____ Driver's License No. _____

Marital Status _____ Spouse's Name_____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to patient _____

Insured Date of Birth _____ Insured Social Security No. _____

Secondary Insurance _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to patient _____

Insured Date of Birth _____ Insured Social Security No. _____

Person responsible for account _____

Address _____ City _____ State _____ Zip _____

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

MEDICAL INFORMATION

Family Physician _____ Date of Last Exam _____

Address _____Phone( ) _____

City _____ State _____ Zip _____

What medications are you presently taking or use on occasion (if any), including **prescription medications, over-the-counter medications** and **vitamins?**

_____

_____

Are you allergic to any MEDICATION you know of? _____

What Pharmacy would you like prescriptions sent to? ***(Please indicate Pharmacy Name and Crossroads and/or Phone number if you have it):***

_____

Are you being treated or have you been treated in the past for ANY of the following:

_____ High Blood Pressure
_____ Low Blood Pressure
_____ Diabetes

_____ Poor Circulation
_____ Phlebitis- which leg? _____
_____ Cancer - Type? _____
_____ Glaucoma
_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Angina
_____ other Heart Problems
explain _____
_____ Emphysema
_____ Tuberculosis
_____ Asthma
_____ other Respiratory problems
explain _____

_____ Ulcers
_____ Hiatal Hernia
_____ other G.I. Problems
explain _____
_____ Arthritis
_____ Gout
_____ Stroke
_____ Epilepsy
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Neuropathy
_____ other Neuro-muscular problems
explain _____
_____ Psoriasis

Smoking Status (Check One):
____Current Every Day Smoker
____Current Someday Smoker
____Former Smoker
____Never Smoker

Describe any operations or hospitalizations you have had and list dates. _____
_____

What problems are you having with your legs or feet today? _____

_____

HEIGHT _____ WEIGHT _____BLOOD PRESSURE_____ SHOE SIZE _____SHOE TYPE _____

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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 them or declined the opportunity to read them and understand the Notice of Privacy Practices. ____Yes ____No

Do you want to be exempt from public reporting? ____Yes ____No

I consent to allow mail to be sent to the address on file. ____Yes ____No

May we call the phone number on file? ____Yes ____No

I consent to allow the office to leave me voicemails. ____Yes ____No

Will you allow internet based delivery reminders like email? ____Yes ____No

You may leave a message with the following person(s):
(please check all that apply)

____Wife ____Husband ____Daughter ____Son

____Other: _____

_____ _____
Print Patient Name Date

_____
Patient Signature

_____
Parent, Guardian or Patient's legal representative
Signature