

# WELCOME TO OUR OFFICE

SEAN M. LIFFITON, D.P.M., P.A.

*Please Print and Complete the Following Information*

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

## INSURANCE INFORMATION

Do you have Medical Insurance? Yes No Is Insurance through your employer? Yes No

Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Is there secondary insurance? Yes No Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

# MEDICAL HISTORY INFORMATION

Do you currently, or have you ever had any of the following: (\*Do Not Know)

	YES	NO	DNK		YES	NO	DNK
FOOT OR LEG INJURIES				DIABETES			
FOOT OR LEG SURGERY				PRONE TO INFECTION			
FOOT OR LEG CRAMPS				CIRCULATION PROBLEMS			
FOOT OR LEG NUMBNESS				HARDENING OF ARTERIES			
FOOT SKIN PROBLEMS				HEART TROUBLE			
TOE NAIL PROBLEMS				VARICOSE VEINS			
LOW BACK PAIN				FAINTING SPELLS			
UNEQUAL LEG LENGTH				KIDNEY DISEASE			
KNEE PAIN				LIVER DISEASE			
WEAK ANKLES				HEPATITIS			
BUNIONS				HIV			
BURSITIS				BLEEDER			
ARTHRITIS				BLOOD DISEASE			
POLIO				ANEMIA			
GOUT				STOMACH ULCERS			
CANCER				EPILEPSY			
ASTHMA				HIGH BLOOD PRESSURE			
RHEUMATIC FEVER							

## ARE YOU ALLERGIC TO OR SENSITIVE TO:

	YES	NO	DNK
ASPIRIN			
CORTISONE			
IODINE / BETADINE			
NOVOCAINE			
PENICILLIN			
SULFA DRUGS			
ADHESIVE TAPE			
FOODS / LIST			
OTHER / LIST			
OTHER / LIST			
OTHER / LIST			

**WHAT MEDICATIONS DO YOU TAKE REGULARLY:**


**MY CHIEF COMPLAINT:**


**THIS CONDITON HAS EXISTED FOR:**

<b>DAYS:</b>	<b>WEEKS:</b>	<b>MONTHS:</b>	<b>YEARS:</b>
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Are you currently under a physician's care?   YES   NO

If yes please explain:


May we contact your physician for your medical records?   YES   NO

I hereby give SEAN M. LIFFITON, D.P.M., P.A., permission to examine and treat my feet.

Patient / Guardian's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_