Welcome to the office of Dr. Anne Ames, DPM • 1301 West 38th Street, Suite 707 • (512) 407-8188

Today's Date _____

Patient Name _____

Address _____

_____

City _____State _____ Zip_____

Birthdate _____

Sex: *(circle)* Male Female

Marital Status *(circle)* Single Married

Separated Divorced Widowed

Patient SS # _____

Occupation _____

Employer _____

Home Phone (_____) _____

Work Phone (_____) _____

Extension: _____

Cell Phone (_____) _____

Email _____

In Case of Emergency, Please Contact

Name: _____

Relationship _____

Phone (_____) _____

Primary Physician _____

Address _____

Phone (_____) _____

Date of last visit _____

Preferred Pharmacy_____

Location _____

Who referred you to our office?_____

Primary Insurance _____

Who is responsible for this account? _____

Relationship to patient _____

Responsible party's birthdate _____

Secondary Insurance _____

Who is responsible for this account? _____

Relationship to patient _____

Responsible party's birthdate _____

Tertiary Insurance _____

Who is responsible for this account? _____

Relationship to patient _____

Responsible party's birthdate _____

Please present all current insurance cards and a photo ID to the receptionist.

Do you smoke? [ ] No [ ] Yes: Packs/day _____ Years _____

Ex-smoker? [ ] No [ ] Yes: Packs/day _____ Years _____

Ex-smokers: When did you quit? _____

Alcohol? *(circle)* None Rarely Moderately Daily Quit

Recreational drugs? *(circle)* None Rarely Moderately Daily Quit

List relationship to you of family members who have had:

Diabetes _____ Foot problems _____

Arthritis _____ Heart attack _____

Stroke _____ High blood pressure _____

Cancer _____ Birth defects _____

Shoe size _____ Height _____ Weight _____

Have you ever been to a podiatrist (foot doctor) before? Yes / No

Name _____

Last visit _____

What is the reason for your appointment with Dr. Ames today? Please include foot, ankle, knee, hip, and leg problems. _____

_____

_____

_____

When did this problem start? _____

_____

What treatments have you tried? _____

_____

Allergies

[ ] Latex / Adhesive tape *(circle)*

[ ] Penicillin [ ] Empirin / Tylenol *(circle)*

[ ] Celebrex [ ] Sulfa drugs [ ] Novocaine

[ ] Aspirin / Advil / Aleve / Motrin *(circle)*

[ ] Morphine [ ] Codeine [ ] Demerol

[ ] Shrimp / Iodine / Merthiolate *(circle)*

[ ] Other medicines *(list below)* [ ] No allergies

_____

_____

_____

_____

List past surgeries you have had.

Surgery: Date:

_____|_____

_____|_____

_____|_____

_____|_____

_____|_____

Please check if you have had any of the following:

[ ] HIV/AIDS	[ ] Anemia	[ ] Angina	[ ] Arthritis
[ ] Artificial heart valves		[ ] Artificial joints	[ ] Asthma
[ ] Back problems	[ ] Chest pain	[ ] Circulation problems	
[ ] Cancer	[ ] Diabetes	[ ] Epilepsy	[ ] Eye problems
[ ] Foot/leg cramps	[ ] Gout	[ ] Headaches	[ ] Heart problems
[ ] Hemophilia	[ ] Hepatitis / Jaundice	[ ] High blood pressure	
[ ] Kidney problems	[ ] Liver disease	[ ] Phlebitis	[ ] Ulcers
[ ] Psychiatric care	[ ] Respiratory (lung) disease	[ ] Stroke	
[ ] Rheumatic fever	[ ] Swelling of ankles/feet	[ ] Varicose veins	
[ ] Other _____	[ ] No major health problems		

Current medications, including prescriptions, over-the-counter drugs, and supplements. (If you have a separate list of your medications, you may give it to the receptionist to copy.)

Medication Dose How often? For treatment of:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information on this form is true and correct to the best of my knowledge. I give my permission to Dr. Anne Ames to administer treatment and perform procedures deemed medically necessary after consultation. I also authorize insurance benefits to be paid directly to Dr. Ames.

Patient Signature_____ Date _____