WHITE SANDS PODIATRY
FOOT AND ANKLE SURGERY CENTER

Patient Information Form

Patient Name____ Date of Birth: ___/____/____
(Last) (First) (MI)

Home Address:_____________________________ City/State___________________ Zip:_________

Home #:____________________ Work #:_____________________ Cell #:______________________

** **Email:**______________________________________SSN:__________________________________

Marital Status:________________________ Age:__________ Sex: M F

Legal Guardian (POA):_______________ Relationship:__________ Phone:_____________________

Emergency Contact:________________ Relationship:__________ Phone:______________________

** **Primary Care Doctor:**_____________________ Location:____________ Phone:______________

Pharmacy:________________________Location:__________________ Phone:_________________

Who is responsible for Payment?:______________________ Relationship:___________________

Address:____________________ City/State:________________ Zip:___________ Phone:________

Who Referred you to us?____

Cellular Phone Carrier: ____

INSURANCE INFORMATION

Primary Company Name:________________Contract:_________________ Group:____________

Address:____________________City/State:_______________ Zip:___________ Phone:_________

Insured Name:_____________________ DOB:_____________ Employer:______________________

Secondary Company Name:________________Contract:_______________ Group:____________

Address:____________________City/State:_______________ Zip:___________ Phone:_________

Insured Name:______________________ DOB:_____________ Employer:______________________

Patient Name:________________________________ Date of Birth:_________________

Please List **ALL MEDICATIONS** you are currently taking (including prescription, over the counter, and herbal medications): ** can attach separate sheet

Name	Dose	How often do you take?

Please list **ALL prior Surgeries**: ** can attach separate sheet

Type of Surgery	Date	Type of Surgery	Date

Social History:

****Alcohol**: __ Never __ No longer use __ History of Abuse __Rare
Type:_________________ __ Moderate __ Daily __ Occasional

****Tobacco**: __ Never __ No longer use - Quit how long ago?__________ __Rare
Type:_________________ __ Moderate __ Daily __ Occasional

****Recreational Drugs**: __ Never__ No longer use - Quit how long ago?_______ __Rare
Type:_________________ __ Moderate __ Daily __ Occasional

How much are you on your feet at work? ___10% ___25% ___50% ___75% ___100%

**** Family History:**	Type	**** Maternal or Paternal**
Heart Disease		
Diabetes		
Cancer /Other		

WSP Staff Use: BP:________ T:________ P:__________ R:________

Your Medical History: ** **Height:**____________ ** **Weight:**__________lbs

ALLERGIES: Medications:____ Other:____________

Anesthesia:_________ Foods:___________ Tape:__________________ NONE:___________

Have you ever had any of the Following?: (please Circle)

Acid Reflux		Fibromyalgia		Mitral Valve Prolapse	
Anemia		Gout		Neuropathy	
Arthritis		Heart Attack		Open Sores	
Asthma		Heart Disease / Failure		Pneumonia	
Back Trouble		Hepatitis		Rheumatic Fever	
Bladder Infections		HIV / AIDS		Sickle Cell Disease	
Abnormal Bleeding		High Blood Pressure		Skin Disorder	
Blood Clots		High Cholesterol		Sleep Apnea	
Blood Trasfusion		Kidney Disease		Stomach Ulcers	
Bronchitis / Emphysema		Liver Disease		Stroke	
Cancer		Low Blood Pressure		Thyroid Disease	
Diabetes		Migraine Headaches		Tuberculosis	

Other Conditions:____

CURRENT PROBLEM:

What Specific Problem brings you into our office today?________________________________

Where is the Pain? (please mark below) How bad is the pain? ___________________________