Patient Demographic Form

Please PRINT

Magee Family Footcare

Date

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Language** other than English

Race *(optional)* ☐ Black - Non Hispanic ☐ American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White- Non Hispanic ☐ Other

Mailing Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

Email Address | **Employment Status** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employeed ☐ Student Full-Time ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student Part-Time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

How did you hear about us? ☐ Billboard ☐ Friend ☐ Magazine ☐ Physician ☐ Website ☐ Other ☐ Employer ☐ Health Fair Event ☐ Mail ☐ Radio ☐ Yellow Pages ☐ Family Member ☐ Insurance ☐ News ☐ Television

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (if self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Mailing Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

Employer | **Employment Status** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employeed ☐ Student Full-Time ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student Part-Time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

MEDICAL INFORMATION

Pharmacy Name | **City**

List current medications ____________________

Illnesses: (check all that apply)
☐ Anemia ☐ Bleeding Disorder ☐ Heapatitis ☐ Kidney Problems ☐ Poor Circulation
☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Liver Disease ☐ Rheumatic Fever
☐ Asthma ☐ Gout ☐ High Blood Pressure ☐ Lung Problems ☐ Stroke
☐ Other ____________________

Allergies: (check all that apply)
☐ Penicillin ☐ Aspirin ☐ Adhesive Tape ☐ Iodine ☐ Seafood
☐ Local Anestetic ☐ Codeine ☐ Latex ☐ Sulfa ☐ Other ____________________

Prior Surgery:
☐ Bone / Joint ☐ Heart ☐ Liver ☐ Lung

Do you smoke? ☐ Yes ☐ No **If yes, how often?** __________ **Did you previously smoke?** ☐ Yes ☐ No

Do you drink? ☐ Never ☐ Occasionally ☐ Moderate ☐ Heavy **Do you exercise?** ☐ Yes ☐ No If yes, is it more than 3 times a week? ☐ Yes ☐ No