www.wetreatfeetpodiatry.com

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D. GORDON MCCRARY, DPM
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PHONE: 410-363-4343 FAX: 410-356-6373

CONFIDENTIAL NEW PATIENT INFORMATION SHEET DATE ____/____/____

NAME: _________________________________ BIRTH DATE: ____/____/____
ALLERGIES: __________________________________ SS#________________________________
MAILING ADDRESS: Street _________________________________
City/Town: ____ State: ________ Zip Code: ________
PHONE: ____________________________ CELL/BUSINESS: ________________/__________________
EMAIL: ____
CAREGIVER: ____ MARTIAL STATUS ________________
**EMERGENCY CONTACT NAME _________________________ PHONE NUMBER:________________
DO YOU TAKE:
BLOOD THINNERS HEART MEDS ANTIDEPRESSANTS ANTIBIOTICS BLOOD PRESSURE MEDS

LIST OF MEDICATIONS:
____

LIST OF OPERATIONS:
____

MEDICAL FAMILY HISTORY-DOES ANYONE IN YOUR FAMILY HAVE/HAD:
DIABETES HIGH BLOOD PRESSURE HIGH CHOLESTEROL STROKE HEART ATTACK

REFERRED BY OR HOW DID YOU HEAR OF US: ____
WHY DID YOU COME TO THE PODIATRIST?
1. ____
2. ____

RIGHT FOOT LEFT FOOT BOTH FEET
**HOW LONG HAVE YOU HAD THIS PROBLEM: ________________________________

PAYMENTS: Patients are responsible for all fees including missed visits, late cancels and returned checks. Payment is expected at the times services are rendered. Payment exceptions must be arranged before treatment. Referrals if needed are the responsibility of the patient to obtain and that charges incurred from the absence of a referral are the responsibility of the patient.
I authorize Wiener and Daniels, DPM, PA and the providers of such company to provide services, and medications, and submit my insurance form, consider my signature “on file” for payment, pictures, and to release any and all records need for insurance processing and communication with other caregivers, including images. I understand the HIPPAA, office privacy policy and have read and understand the above and agree to be personally responsible for all charges and fees.

Signature of patient or responsible party: ___________________________________

Printed name: ____ DATE: / /

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PATIENT NAME: ___________________________________DATE OF BIRTH_____

PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME
PRIMARY ID#	SECONDARY ID #
PRIMARY POLICY HOLDER NAME AND SS#	SECONDARY POLICY HOLDER NAME AND SS#
POLICY HOLDER RELATIONSHIP TO PATIENT	2ND POLICY HOLDER RELATIONSHIP TO PATIENT

PRIMARY CARE DOCTOR NAME:
PRIMARY CARE DOCTOR PHONE NUMBER:
LAST DATE YOU SAW YOUR PRIMARY CARE DOCTOR:
DO YOU SEE AN ENDOCRINOLOGIST? YES OR NO
IF YES WHAT IS YOUR ENDOCRINOLOGIST NAME AND PHONE NUMBER:
LAST DATE YOU SAW YOUR ENDOCRINOLOGIST:

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PATIENT NAME: ____________________________ DATE OF BIRTH_____________

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONAIRE

FOOT PROBLEMS:

AMPUTATION(S)	YES	NO	SPECIFY: ______________________________
BROKEN FOOT	YES	NO	SPECIFY: ______________________________
BUNIONS	YES	NO	
COLD FEET	YES	NO	
CONTRACTED TOES	YES	NO	
CORNS/CALLOUSES	YES	NO	
FROSTBITE	YES	NO	
FUNGUS NAILS	YES	NO	
FUNGUS SKIN	YES	NO	
HEEL PAIN	YES	NO	
INFECTION(S)	YES	NO	
INGROWN NAILS	YES	NO	
NEUROPATHY	YES	NO	
NUMBNESS/TINGLING	YES	NO	
PLANTAR FASCITIS	YES	NO	
ARCH PAIN	YES	NO	
POOR CIRCULATION	YES	NO	
RAYNAUDS	YES	NO	
SORES	YES	NO	
SURGERY (FOOT/FEET)	YES	NO	SPECIFY: ______________________________
TIRED FEET	YES	NO	
ULCER (FEET/LEG)	YES	NO	
WALKING ISSUES	YES	NO	WHAT: ______________________________

CIRCULATORY SYSTEM

ARTERY DISEASE	YES	NO
BLOOD CLOTS	YES	NO
CHOLESTEROL HIGH	YES	NO
CRAMPS FEET/LEGS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
STROKE	YES	NO
TAKING COUMADIN	YES	NO

CONSTITUTIONAL/PSYCHOLOGICAL SYSTEM

ANXIETY	YES	NO	
CHILLS	YES	NO	
DEMENTIA	YES	NO	
DEPRESSION	YES	NO	
DIZZINESS	YES	NO	
FAINTING	YES	NO	
WEIGHT ISSUES	YES	NO	SPECIFY: ______________________________

DERMATOLOGICAL SYSTEM

CANCER	YES	NO	WHAT KIND: ______________________________
DERMATITIS	YES	NO	
DRY SKIN	YES	NO	
PSORIASIS	YES	NO	
ECZEMA	YES	NO	

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PATIENT NAME: ___________________________ DATE OF BIRTH______

ENDOCRINE/GU/GI

BPH (PROSTATE)	YES	NO	
DIABETES	YES	NO	
HEPATITIS	YES	NO	
PREGNANT	YES	NO	NOT SURE
RENAL/KIDNEY STONES	YES	NO	
THYROID DISEASE	YES	NO	
ULCER (GI)	YES	NO	

HEAD/HEART/LUNGS/NECK/EYE/EAR/THROAT

ACID REFLUX	YES	NO	
ASTHMA	YES	NO	
CATARACTS	YES	NO	
COPD	YES	NO	
EMPHYSEMA	YES	NO	
GLAUCOMA	YES	NO	
HEADACHES	YES	NO	
HEART ATTACK	YES	NO	
MIGRAINE	YES	NO	
PNEUMONIA	YES	NO	
SMOKE	YES	NO	FORMER

HEMATOLOGIC IMMUNOLOGICAL SYSTEM INFECTION DISEASE

ANEMIA	YES	NO
HIV	YES	NO
IMMUNE PROBLEM	YES	NO
LYME DISEASE	YES	NO
TICK BITE	YES	NO
TB	YES	NO
MRSA	YES	NO

MUSCULOSKELETAL SYSTEM

ARTHRITIS	YES	NO	
BACK PROBLEM	YES	NO	
GOUT	YES	NO	
IMPLANT	YES	NO	
JOINT REPLACEMENT	YES	NO	SPECIFY: ______________________________
JOINT STIFFNESS	YES	NO	
PLATES/SCREWS	YES	NO	SPECIFY: ______________________________
SURGERY (OTHER)	YES	NO	SPECIFY: ______________________________

NEUROLOGICAL SYSTEM

EPILEPSY	YES	NO
MS	YES	NO
NEUROPATHY	YES	NO
PARKINSON'S DISEASE	YES	NO

OTHER: ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ________________________________

DATE: _______/_________/___________

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