NORTHERN BLVD FOOTCARE: PLEASE NOTE QUESTIONS REQUIRED BY HEATLH CARE ACT

NAME FIRST _____ **MIDDLE** _____ **LAST**_____

ADDRESS: _____ **AGE:**_____

_____

Responsible Party if Minor: _____

E-MAIL _____ **MARITAL STATUS** S-M-D-W **PREGNANT?** Y-N

PHONE H_____ C_____W _____

PHARMACY NAME STREET AND TOWN Date **Birth**_____ **SEX** M-F

_____

RACE White / African Amer. / Asian / Hispanic / Other **Language** English / other

Primary Insurance Name/ID _____

Secondary Insurance Name/ID _____

I**S PATIENT THE INSURED?** Y / N **Ethnicity:** Hispanic / Non Hispanic

POLICY HOLDER NAME AND DOB_____

ADDRESS OF INSURED_____

EMERGENCY CONTACT:_____ **PHONE:** _____

HT:_____ **WEIGHT:** _____**ALCOHOL?** No / Socially / More than Socially

MEDICATIONS AND DOSAGE: PLEASE PRINT:_____

_____

_

_____

_

_____

_

MEDICAL CONDITIONS:_____ _

_____

_

ALLERGIES:_____

SMOKE: Y N **PACKS/DAY?** _____ **Primary Doctor?** _____

_

HOW WERE YOU REFERRED TO OFFICE? _____
REASON FOR TODAYS VISIT?_____
_____
_
_____
_
SIGNATURE:_____DATE:_____
Northern Blvd. FOOTCARE: PLEASE NOTE QUESTIONS REQUIRED BY HEATLH CARE ACT
I CERTIFY ABOVE INFO IS CORRECT TO MY KNOWLEDGE, I ALSO AUTHORIZE William Hansen DPM TO ALLOW ME TO ELECTRONICALLY SIGN DOCUMENTS.