First Visit Intake Form

Date ______________________

Dr. P. Atlas   Dr. N. Condro   Dr. G. Atlas   Dr. E. Kaplan   Dr. L. Rosenfeld   Dr. M. Del Rosso

Monticello • Liberty • Middletown • Monroe • Port Jervis • Callicoon

Please Print:

Patient (first, middle, last)______________________ M / F Age___Date of Birth__________

LOCAL Address______________________City________________St____Zip_______

I am here month of ______________ To __________________

Vacation or Away Address______________________City________________St____Zip_______

I am there month of ______________ To __________________

Home Phone:________________Work Phone______________ SS# ________________

E-Mail Address ________________ Cell # ______________________

Place of Employment______________________ Marital Status----S, M, W, D

Student Status: (Circle) Full / PT School Name______________Have you notified insurance of college Attendance ?Y / N

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If this visit is for an injury, was it due to an auto accident or job-related injury? Y / N

If yes, name and address of Insurance Carrier______________________Where did it occur?______________

When did it occur? ________ How did it occur?______________________Was employer notified? Y / N

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Have you had previous foot treatment? If yes, please explain______________________

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How did you hear about our services?______________________

Medical Doctor:________________Address:________________Date of last visit__________

Pharmacy Name:________________ Address: ________________Tel ______________

Do you allow Family Footcare Group, LLP to access your medication history online? Y / N   Fax:______________

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PAST OR PRESENT MEDICAL CONDITIONS-PLEASE CHECK IF YES

___Childhood diseases
___Stomach problems (Ulcers, Colitis)
___Diabetes (Insulin or Non-Insulin)
___Rheumatic Fever
___Epilepsy
___Coumadin or other blood thinners

___Osteo (aging) Arthritis
___Rheumatoid Arthritis
___Kidney Disease
___Cancer
___Tuberculosis
___Fibromyalgia

___High Blood Pressure
___Low Blood Pressure
___Asthma/Emphysema
___Hepatitis
___Blood Disorders
___Lyme Disease
___Thyroid Condition

___Joint Replacement
___Gout
___Heart Condition
___Liver Disease
___Mitral Valve Prolapse (Heart Murmur)
___Stroke
___ Smoking, Present / Past / Never

Have you had previous surgery?______What Type______________________

Do you have to be pre - medicated with antibiotics before having dental work done? Yes / No

Height: ___________ Weight: ___________ Blood Pressure: ___________

ALLERGIES: CHECK ALL THOSE THAT APPLY:

____Penicillin ___Other Antibiotics____Cortisone____Aspirin____Dental Anesthesia____Other Medications____Iodine (Seafood) None Known _____

Latex _______ Bandaids ________ Tape _________ Other ______________

Contact in case of emergency:______________________ Phone #______________

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IF THE PRIMARY INSURANCE CARD HOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent/Spouse name:______________________SS#______________Date of Birth__________

Parent/Spouse Place of Employment______________________

If other than patient, send statements to: (Name, Address, Phone #______________________

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Chief Complaint ____

Onset, Duration & History ____

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Trauma ______________________ Medication ______________________

Social Hx: Alcohol Daily _______ Y / N Past or Current Drug Use Y / N

Family Hx: Diabetes ☐ Arthritis ☐ Cardiac ☐ other ☐

Psychiatric (orientation/mood) ____