WELCOME

Dr. Tony D. Quinton, DPM

Date: _____ How did you hear about us? _____

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Gender: Male/Female SSN: _____

Employer Name: _____ Occupation: _____

Federal Healthcare Reform Requires We Ask the Following:

Marital Status: S M W D P Primary Language: _____

Race: American Indian Asian African American Native Hawaiian White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Emergency Contact Name: _____ Phone: _____

If Patient is a Minor Please fill out the following:

Parent of Legal Guardian's Name: _____

Address: _____ Date of Birth: _____

SSN: _____ Phone Number: _____

Insurance:

Primary Insurance Co: _____ Policy Holder: _____

Policy Holder's Birth Date: _____ SSN: _____ Relationship to patient _____

Secondary Insurance Co: _____ Policy Holder: _____

Policy Holder's Birth Date: _____ SSN: _____ Relationship to patient _____

Pharmacy: _____

Financial responsibility and Assignments of Benefits: I hereby acknowledge and understand that I am financially responsible for all charges incurred on my (or my dependent's) behalf whether or not paid by insurance. I authorize the use of this signature on all insurance submissions and that my insurance benefits be paid directly to Dr. Quinton. I understand that it is the policy of this office for accounts over 90 days to be turned over to collections unless other arrangements are made. In the event that my account is sent to collections, I acknowledge responsibility for any additional cost incurred. I also certify that I have declared all insurance coverage to this office. **I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient or Guardian Signature: _____

Patient Name: _____ Date: _____ Age: _____

Chief Complaint: _____

Injury: _____ How did it occur? _____

Referring Physician: (if applicable) _____

Personal Medical History:

Cigarette/Tobacco Use? Yes No #of years _____ Occasional ½ pk/day 1 pk/day 1+ pk/day Quit date: _____

Aids/HIV	YES NO	Hemophilia	YES NO	Rheumatic Fever	YES NO
Anemia	YES NO	Headaches	YES NO	Shortness of Breath	YES NO
Arthritis	YES NO	Heart Disease	YES NO	Sinus Problems	YES NO
Artificial Heart/Joints	YES NO	Hepatitis/Jaundice	YES NO	Special Diet	YES NO
Asthma	YES NO	High Blood Pressure	YES NO	Stroke	YES NO
Back Problems	YES NO	Hypothyroidism	YES NO	Swelling in Feet/Ankle	YES NO
Bleeding Disorder	YES NO	Kidney Problems	YES NO	Swollen Neck Glands	YES NO
Cancer	YES NO	Liver Disease	YES NO	Thyroid Problems	YES NO
Chemical Dependency	YES NO	Low Blood Pressure	YES NO	Tuberculosis	YES NO
Circulatory Problems	YES NO	Nervous Problems	YES NO	Ulcers	YES NO
Diabetes	YES NO	Phlebitis	YES NO	Varicose Veins	YES NO
Insulin Resistance	YES NO	Psychiatric Care	YES NO	Venereal Disease	YES NO
Depression	YES NO	Radiation Treatment	YES NO	Weight Change	YES NO
Foot/Leg Cramps	YES NO	Respiratory Disease	YES NO	Fainting	YES NO
Gout	YES NO				

Please List All Current Illnesses: _____

Please List Hospitalizations/Surgeries: _____

Primary Physician: _____

Are you currently taking Oral Contraceptives: YES NO

Please List All Medications You Are Currently Taking: (example- Prescriptions, Vitamins, and Over The Counter)

_____

_____

Family Medical History:

Please Circle All That Apply To Your Family And Mark The Line of Relationship:

Diabetes	YES NO	Father Mother	**Heart Disease**	YES NO	Father Mother
Foot Problems	YES NO	Father Mother	**Kidney Disease**	YES NO	Father Mother

ALLERGIES:

___Adhesive Tape/Latex	__ Anticoagulant Therapy	__ Aspirin	__ Codeine
__ Demerol	__ Iodine	__ Local Anesthetics	__ Novocain
__ Penicillin	__ Seafood	__ Sulfa	__ Other: _____
___ **NO KNOWN DRUG ALLERGIES**			_____

I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Signature: _____

rev 10/2015