PATIENT INFORMATION

[ ] Mr. [ ] Mrs. [ ] Ms.   Patient ID _

Name: ______________________

Address: ______________________

____

City,State,Zip: ______________________

Phone: ____________ [ ]Home [ ]Work [ ]Other

Phone: ____________ [ ]Home [ ]Work [ ]Other

Cell phone: ____________

Date of Birth: ____________ SSN: ____________

Age: ____________ Sex: [ ]M [ ]F

Marital Status: [ ]Married [ ]Single

PATIENT EMPLOYMENT

Employer: ______________________

Occupation: ______________________

SPOUSE

Name: ______________________

Spouse Employer: ______________________

Occupation: ______________________

PERSONAL CONTACTS

I hereby give consent to Dr. Ashton & Associates or assistants to release information concerning my medical condition & treatment to the following people.

Contact Name	Relation to Patient	Phone Number

Emergency Contact: ____________ Phone: ____________

PRIMARY INSURANCE

Insured: [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Name: ______________________

Insured Phone: ______________________

Patient Relationship to Insured: ____________

Date of Birth: ____________ SSN: ____________

Insurance Company: ______________________

Insured ID: ______________________

Policy Group: ______________________

PARENT OR GUARANTOR

Guarantor Name: ______________________

Guarantor Address: ______________________

Guarantor City, State, Zip: ______________________

Guarantor DOB: ____________ SSN: ____________

Whom may we thank for referring you? ____________

Referring Physican: ____________

Primary Care Physician: ____________

Former Podiatrist: ____________

Last Visit Date to PCP: ____________

Referring Physican's Phone: ____________

What is the nature of your chief foot complaint? ______________________

____

Are you in good health?	Yes ____	No ____
Are you now or have you been under a physician's care during the past two years?	Yes ____	No ____
Are you subject to prolonged bleeding?	Yes ____	No ____
Is there a personal or family history of diabetes?	Yes ____	No ____
Have you ever experienced any effects from "Novocaine", Penicillin, or any other medications?	Yes ____	No ____
Have you been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver involvement? If yes, which ones? ____________	Yes ____	No ____

Height: ________ Weight: ________ Shoe Size: ________

I have been given an opportunity to read the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future.

______________________ ______________________

Signature of patient or guardian   Date

I hereby give my permission to Dr. Ashton and associates or assistants to administer and to perform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

______________________ ______________________

Signature of patient or guardian   Date