PATIENT INFORMATION

Kenrick J. Dennis, DPM

Last Name First Name Initial

NAME

ADDRESS

CITY STATE ZIP

DATE OF BIRTH SEX: M F MARITAL STATUS: S M W D

By what name would like us to address you? _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Occupation _____ Employer _____

Name in Full of your (Husband, Wife, or Parent) _____

Spouse (or parent) employed by _____ Occupation _____

Party Responsible for Payment of Account _____

In Case of Emergency (Name) _____ (Phone #) _____

Who may we thank for your referral? _____

Primary Care Physician (& phone) _____ Last Visit: _____

Insurance Co: 1

_____

Insured's Name: _____

I.D. #: _____

Group #: _____

Insurance Co: 2

_____

Insured's Name: _____

I.D. #: _____

Group #: _____

PLEASE SIGN and DATE BELOW

1) I authorize the release of any medical information necessary to process a claim on my behalf.

_____ Date _____

Patient or Legal Guardian

2) I authorize payment of medical benefits to the undersigned physician or supplier for services rendered on my behalf.

_____ Date _____

Patient or Legal Guardian

PATIENT INFORMATION – (continued) MRN # _____

MEDICATIONS: Include prescriptions, over-the-counter medications and vitamins:

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: __ No ___ Yes (please provide details below)

	Medication	Describe reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

Pharmacy with phone # or Cross streets - _____

SOCIAL HISTORY:

Alcohol frequency? (circle): none 1-2 / yr 1-2/ mo 1-2 / week 3-5 / week daily

Type (circle): Beer Wine Liquor

Employment status (circle): full-time part-time retired disabled homemaker unemployed student

How many hrs/day are you on your feet (circle)? <1 1-3 3-6 6-10 >10 varies

Tobacco Use? (circle) : No Yes Type: _____ Packs/day: ____ # of years: ____

Past history of tobacco? (circle): No Yes

Race (check): ____ Asian ____African American ____Pacific Islander/Hawaiian ___White

___American Indian/Alaska Native (North/South American)

Ethnicity: (check one) _____Hispanic or Latino _____Non-Hispanic or Latino

Primary language: _____

VITALS:

Height: _____ Weight: _____ Shoe Size: _____

MEDICAL:

Surgeries (& year) you have had: _____

(other than foot surgery) _____

_____

What is the reason for your visit to the office today? _____

_____

How long has this been a problem? _____

Have you seen any other doctors about this problem? __ Yes __ No

Dr's name: _____

Who is your previous podiatrist? _____ Last visit? _____

Have you ever had foot surgery? ___ Yes ___ No

What was done (& how long ago)? _____

_____

Is there anything else you would like the doctor to know? _____

_____

_____

Please " ✔ " if you or a family member have had any of the following?

	You	Mother	Father	Sister	Brother
AIDS	( )	( )	( )	( )	( )
HIV	( )	( )	( )	( )	( )
Anemia	( )	( )	( )	( )	( )
Arthritis	( )	( )	( )	( )	( )
Asthma	( )	( )	( )	( )	( )
Back Problems	( )	( )	( )	( )	( )
Bleeding Problems	( )	( )	( )	( )	( )
Cancer (type)	( )	( )	( )	( )	( )
Chronic Fatigue Syn	( )	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )	( )
Epilepsy/Seizures	( )	( )	( )	( )	( )
Eye Problems	( )	( )	( )	( )	( )
Fainting	( )	( )	( )	( )	( )
Foot/leg cramps	( )	( )	( )	( )	( )
Gout	( )	( )	( )	( )	( )
Heart Disease	( )	( )	( )	( )	( )
Hemophilia	( )	( )	( )	( )	( )
Hepatitis, Type __	( )	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )	( )
High Cholesterol	( )	( )	( )	( )	( )
Kidney Problems	( )	( )	( )	( )	( )
Low Blood Pressure	( )	( )	( )	( )	( )
Parkinson's Dis.	( )	( )	( )	( )	( )
Phlebitis	( )	( )	( )	( )	( )
Rheumatic Fever	( )	( )	( )	( )	( )
Shortness of Breath	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )
Swelling	( )	( )	( )	( )	( )
Thyroid Hypo/Hyper	( )	( )	( )	( )	( )
Tuberculosis	( )	( )	( )	( )	( )
Varicose veins	( )	( )	( )	( )	( )

Kenrick J. Dennis, DPM
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Please review Notice of Privacy Practices prior to filling in this page)

I acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ Date of Birth:_____
(please print)

I request that any and all communications to me (by telephone, mail or otherwise) by ***Kenrick J. Dennis, DPM*** and/or his staff be handled in the following manner:

- For written communications: Address to: _____
  (if different from ***Patient Information Sheet***) _____
  _____

- For telephone communications: Please list the phones numbers you would like us to use to contact you. Please leave a blank by any # we should **not** use.

  ____ Home (_____) _____
  ____ Office (_____) _____
  ____ Cell Phone (_____) _____

  May we leave a message?
  Yes ☐ No ☐

_____ _____
Patient Signature **Date**