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 you 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 _____

Party Responsible for Payment of Account _____

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

Who may we thank for your referral? _____

Primary Care Physician: _____ Last visit: _____

Insurance Co: 1 Effective Date ____

Insured's Name: _____

I.D. #: _____

Group / Policy #: _____

Insurance Co: 2 Effective Date ____

Insured's Name: _____

I.D. #: _____

Group / Policy #: _____

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 # _____ Date:

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

_____ _____

_____ _____

_____ _____

_____ _____

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

	Allergies	Describe reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

Pharmacy: with phone # OR Cross Streets - _____

SOCIAL HISTORY:

Alcohol: Frequency ? (circle): 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** __ **White**

__ **American Indian (North/South America) / Alaska Native**

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 was 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 have or a family member have had any of the following?

	You	Mother	Father	Sister	Brother
AIDS	( )	( )	( )	( )	( )
HIV	( )	( )	( )	( )	( )
Anemia	( )	( )	( )	( )	( )
Arthritis	( )	( )	( )	( )	( )
Asthma	( )	( )	( )	( )	( )
Back Problems	( )	( )	( )	( )	( )
Bleeding Problems	( )	( )	( )	( )	( )
Breathing 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	( )	( )	( )	( )	( )
Sinus Problems	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )
Swelling	( )	( )	( )	( )	( )
Thyroid Condition	( )	( )	( )	( )	( )
Tuberculosis	( )	( )	( )	( )	( )
Varicose Veins	( )	( )	( )	( )	( )

Durable Medical Equipment:

Supplies Dispensed in the office:

Many of the items (*such as post-operative shoes, orthotic devices, arch supports, braces, bandages, topical medicines*) that are dispensed by the doctor in this office are not covered by your insurance. We want you to be informed of this, and make sure you understand that you are responsible for paying for these items when they are received. These items are **not** returnable.

Please sign below to acknowledge and accept the policy for supply items dispensed in this office.

_____ _____

Patient (or Guardian) Signature Date

_____

Printed Name

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**