MRN __________

PATIENT INFORMATION

Kenrick J. Dennis, DPM

__________________________________ ______ __________________________________

First Name MI Last Name

By what name would you like us to address you? __________________________________

Date of Birth: __ __/__ __/__ __ __ __ Gender: M F

Home Address: ____

City: __________________________________ State: ____________ Zip: ______________

Is your mailing address the same as your home address? Yes / No

Cell Phone: _____________________________ Home Phone: ___________________________

Email: __________________________________

Race: Asian ☐ Black/African American ☐ Hispanic ☐ White ☐ Pacific Islander ☐ Other ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other ☐

Preferred Language: ______________________ Marital Status: (circle) S M W D

Employment Status: Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed ☐

Employer: ______________________________ Occupation: ____________________________

Primary Care Physician: _________________________________ Last Visit: _____________________

Preferred Pharmacy: ______________________ Phone Number: _________________________

In case of emergency, contact:

__________________________ __________________________ __________________________

Name Phone Number Relation

Who may we thank for your referral? __________________________________

Insurance Authorization

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

__________________________ __________________________

Signature Date

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

__________________________ __________________________

Signature Date

Only complete if the patient is **not** the primary insured:

__________________________ __________________________ __________________________

Primary Insured's Name Date of Birth Relation to Patient

MRN __________

Height: ___________________ Weight: ___________________ Shoe Size:_________________

How many hours per day are you on your feet? (circle) <1 1-3 4-6 7-10 >10

Are you **allergic** to any medications? No ☐ Yes ☐ (Please provide details below)

	Medication	Describe Reaction
1.		
2.		
3.		

Current Medications: (Attach a list, if preferred)

Medication	Dosage	Frequency

What is the reason for your office visit today? ____

____

How long has this been a problem? ____

Have you seen any other doctors about the same problem? No ☐ Yes ☐

Who was your previous podiatrist? _________________________ Last visit? ________________

Is there anything else you'd like the doctor to know? _______________________________________

____

Have you ever had foot surgery? No ☐ Yes ☐

Surgery Type	Year

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

Type (circle): Beer Wine Liquor

Tobacco Use? No ☐ Yes ☐ Type: _______________ Packs/day: _____ # of years: ______

Past history of tobacco use? No ☐ Yes ☐

MRN __________

Medical History

	Please check any of the conditions that **YOU** have.	Please check any condition that an **IMMEDIATE FAMILY** member (mother, father, siblings) has/had.
Anemia	☐	☐
Back Problems	☐	☐
Bleeding Problems	☐	☐
Breathing Problems	☐	☐
Cancer ___________ (type)	☐	☐
Chronic Fatigue Syndrome	☐	☐
Diabetes	☐	☐
Epilepsy/Seizures	☐	☐
Eye Problems	☐	☐
Fainting	☐	☐
Foot/Leg Cramps	☐	☐
Gout	☐	☐
Heart Disease	☐	☐
Hepatitis, Type _____	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
HIV	☐	☐
Kidney Problems	☐	☐
Low Blood Pressure	☐	☐
Parkinson’s Disease	☐	☐
Phlebitis	☐	☐
Rheumatic Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Problems	☐	☐
Stroke	☐	☐
Swelling	☐	☐
Thyroid Condition	☐	☐
Tuberculosis	☐	☐
Varicose Veins	☐	☐

MRN __________

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: ____________________________ Date: _________________________________

Parent or authorized representative (if applicable): _______________________________________

Signature: ____________________________________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: ____________________________ Date of Birth: ____________________________

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 <u>written</u> communications, address to: ☐ Same address as on page 1

  ☐ Alternative address: __________________________

  ____

- For <u>telephone</u> communications, please list the phone numbers you would like us to use to contact you. Please leave blank any number we should **not** use.

  ☐ Cell ___________________________

  ☐ Home ___________________________

  ☐ Work ___________________________

  May we leave a message? No ☐ Yes ☐

_______________________________________ __________________________

Patient Signature Date

MRN __________

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, etc.) 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