Las Cruces Family Foot & Ankle

Patient Full Name_____ E-mail_____

Address_____City_____State_____Zip_____

Phone: Home_____Cell_____

May we leave medical information on the phone, and/or e-mail you have provided for us? Yes___ No ___

DOB_____ Age_____ Sex_____ SS#_____

Primary Language_____ Race_____

Please circle one ethnicity: Hispanic/Non-Hispanic

Marital Status-S M D W Sep. Spouse's name_____ Referred By_____

Your Employer_____Occupation_____

Address_____Phone_____

Emergency
Contact/Relationship_____Phone_____

Family Physician_____ Date of Last Visit_____

Party Responsible for Payment of Account_____

Preferred Pharmacy_____Location_____

What specific problem brings you to our office today?

_____

_____

Have you been seen by a podiatrist or other doctor for this issue? YES NO _____

Please specify which ankle/ foot: L R BOTH

Was this a work-related injury? YES NO

Height_____ Weight_____ Shoe Size_____

Are you pregnant? YES NO