Welcome to the Office of
William H. FitzPatrick, DPM & Gay L. Gustafson, DPM

Patient Name ______________________________ Birth Date ______________
LAST FIRST MIDDLE

Name of (husband, wife, or parent) ______________________________

Address ______________________ City ______________ Zip __________

Home Phone ______________________ Business/Cell ______________________

Employer ______________________ Occupation ______________________

Family Physician ______________________ Date last seen ______________

Who told you about our office? ______________________ ☐ Phone book ☐ Sign

Former podiatrist ______________________ Date last seen ______________

Name & address of nearest relative ______________________________

INSURANCE INFORMATION

(Please Present Insurance Card / Information to Receptionist)

MEDICAL INFORMATION

What is your foot problem? ______________________________

How long have you had it? ______________________________

List all medications you take ______________________________

Allergies to medications ______________________________

Do you currently smoke? ☐ yes ☐ no Do you drink any alcohol daily? ☐ yes ☐ no

List any past surgery ______________________________

Have you ever been treated for any of the following? (check all that apply)

☐ Diabetes	☐ High blood pressure	☐ Osteoporosis
☐ Sciatica	☐ Heart condition	☐ Depression
☐ Arthritis / Gout	☐ Stroke	☐ Thyroid disorder
☐ Lung disorder	☐ Circulation problems	☐ Nerve disorder
☐ Short leg (R/L)	☐ Kidney disease	☐ Alzheimer’s disease
☐ Stomach disorder	☐ Liver disease	☐ Cancer ______________ type

Other ______________________________

Has anyone in your family been diagnosed with diabetes? ☐ yes ☐ no

If so, what is his or her relationship to you? ______________________________

CONSENT:
I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet. I give permission to release information necessary for my insurance company to process my claim.

Signed ______________________________ Date ______________