Welcome to ABQ Podiatry

ABQ Podiatry

Foot Surgery & Medicine

William H. FitzPatrick, DPM - Gay L. Gustafson, DPM - Gary D Prant, DPM

Patient Name_____ Birth Date _____
LAST FIRST MIDDLE

Name of (husband, wife, or parent) _____

Address_____ City_____ Zip _____

Home Phone_____ Business/Cell_____ Email _____

Employer_____ Occupation _____

Family Physician_____ Date last seen _____

Former Podiatrist_____ Date last seen _____

Who told you about our office?_____ □ Internet □ Phone book □ Newspaper □ Street sign

Emergency Contact: Name_____ Phone_____

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 _____

Height (ft/in)_____ Weight (lbs)_____

Do you currently smoke? □ yes □ no □ never Do you drink any alcohol? □ daily □ occasionally □ no □ never

List any past surgery _____

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

	Self		*Self*		*Self*
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 (list type below)	□

Other _____

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 as well as obtain and review my prescriptions.

Signed_____ Date _____