WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.

415 W Russ Road, Greenville, Ohio 45331

Patient # _____

PATIENT INFORMATION: *PLEASE PRINT*

Name _____
Last Name First Name MI

Street Address_____ **P.O. Box**_____ Home Phone (_____)_____

City_____ State_____ Zip_____ Cell (_____) _____

Sex: ☐ M ☐ F **Birthdate:** _____ SS# _____ **Marital Status**: ☐ Single ☐ Married ☐ Widowed

Preferred Appointment Reminder: ☐ Text ☐Call Email, if using our patient portal _____

Emergency contact: _____ Relationship_____ Phone (_____) _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Island ☐ White

Advanced Directives: ☐None ☐ Living Will ☐ Medical durable power of attorney ☐ other _____

Employment: Employer _____ Business Phone (_____)_____ ☐ Retired

Work Injury: Is this a work related Injury? ☐ Yes ☐ No Date of Injury: _____ Claim #:_____

RESPONSIBLE PARTY INFORMATION

Name (if different from the patient)_____ Phone_____

Complete Address_____

INSURANCE INFORMATION

(MUST COMPLETE THIS SECTION, PLEASE)

Primary Ins._____ Subscriber_____ DOB_____ Relationship _____

Secondary Ins._____ Subscriber_____ DOB_____ Relationship_____

MEDICAL INFORMATION

Do you have **Diabetes**? ☐ Yes (☐ Type 1 ☐ Type 2) ☐ No If female, are you **pregnant**? ☐ Yes ☐ No

Alcohol Use: ☐ Never ☐ Current ☐ Past What Type? ☐ Beer ☐ Wine ☐ Liquor

Do you use tobacco products? ☐ Never ☐ Current ☐ Past If so, what type? _____

How many per day? _____ How long in use? _____ If applicable, how long ago did you quit? _____

Interest in Quitting: ☐ Yes ☐ No **Concerns about tobacco use in household:** ☐ Yes ☐ No

Do you use e-cigarettes? ☐ Never ☐ Yes ☐ No If so, how many per day? _____ How long in use? _____

Substance abuse? ☐ Never ☐ Current ☐ Past How Often? _____ If so, what type? _____

PLEASE TURN OVER PAGE

Allergies or **Sensitivities to**: ☐ Sulfa ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐Seasonal

☐ Medications_____ ☐ Food_____

☐ Anesthesia_____ ☐ None Known

Please list all **medications** you take on a regular basis. ***(If you have a list of your medications, our office staff will photocopy it.)***

_____

_____

_____

_____

_____

_____

_____

Family doctor: _____ **Pharmacy:** _____

Signature _____ **Date** _____

Consent to Photograph

Name: _____ **Date of Birth:** _____/_____/_____

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Western Ohio Podiatric Medical Center, Inc will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view then or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Western Ohio Podiatric Medical Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative."

Signature:_____ **Date**: _____

Note: This consent does not authorize the use of images for the other purpose, such as teaching or publicity. A separate consent for photography for should be used for such purpose.