

**Foot Care Specialists, PLLC
LaWanda Bailey-Rayner, DPM**

Personal Information

Name: _____
Address: _____
City _____ State: _____
Phone #: _____ Alt Phone #: _____
Date of Birth: ___/___/___ Social Security #: ___/___/___
Age: _____ Sex: **M / F** Height _____ Weight _____ Shoe Size: _____
Marital Status: _____ Email address: _____
Referred By: _____
Patient's Employer: _____ Phone#: _____
Occupation: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: ___/___/___

Emergency Contact: _____ Relationship to Patient: _____
Address: _____ Phone #: _____

Primary Care Physician: _____
Pharmacy Name: _____

Primary Problem: _____

How long have you had this problem? : _____
Have you ever been treated for this problem, **IF** yes, explain? : _____

Could you be pregnant? () YES () NO
Are you a smoker? _____ Do you have a history of smoking? _____
How many packs a day? _____

Do you consume Alcoholic Beverages? _____
Drinks per day/or per week? _____

Do you have artificial joints? _____ IF so, which joints? _____

Do you have a Heart Valve Implant? _____ Please explain: _____

Have you had any or any other surgeries? Yes or No If so please list below:

MEDICAL INFORMATION

Are you allergic to any medications? **IF** yes please list medication and reaction:

Do you have problems with local anesthetics such as Novocaine or Lidocaine? **IF** yes please explain:

Are you allergic to **tape** or **latex**? _____ Do you take Aspirin? _____
Do you take **Coumadin** or a **Blood Thinner**? _____

List your current medications: _____

Please circle any problems you have or have had with below:

Heart	Kidneys	Lupus
Arthritis	Stroke	Gout
Burns	Circulation	Anemia
Skin	Nerves	Liver
Angina	Hypertension	Asthma
Cancer	Hypercholesterolemia	Intestines
HIV/AIDS	Thyroid	Rheumatic Fever
Diabetes	Healing	Tuberculosis
Stomach Ulcers	Eyes	Frequent Infections

Other: _____

I certify to the best of my knowledge that all of the information above is correct.

Signature

Date

FAMILY HISTORY

Are your parents still living? Yes No

If NO, what was the cause of death? _____

Please check the following health condition associated with mom,dad,grandparents.

Relationship

Alzheimer's Disease	
Aneurysm (Specify)_____	
Arthritis	
Asthma	
Cancer (Specify)_____	
Congestive Heart Failure	
COPD	
Dementia	
Diabetes	
DVT (Blood Clot)	
Emphysema	
Foot Deformities (Specify)	
GERD (Heart Burn)	
Heart Disease	
Hepatitis	
Hypercholesterolemia	
Hypertension (High Blood Pressure)	
Hyperthyroidism	
Hypothyroidism	
Kidney Disease	
Lung Disease	
Lupus	
Migraines	
Myocardial Infarction(MI-Heart Attack)	
Parkinson's Disease	
Pneumonia	
PVD (Peripheral Vascular Disease)	
Renal Failure	
Stomach Ulcer	
Stroke	
Tumor	
Toenail Problems	
Tuberculosis	
Unknown	
Unknown of Family History	
Other Disease	

I understand that I am financially responsible for all charges not paid by insurances (such as deductibles, non-covered services, co-pays, co-insurances). I hereby authorize the doctor to release all information necessary to secure all insurance benefits and hereby assign all insurance benefits to Foot Care Specialists, PLLC. I authorize the use of this signature on all insurance submissions. This signature gives my permission for treatment by Dr. LaWanda Bailey-Rayner.

Responsible Party Name

Responsible Party Signature

Date