



210.829.8770 (v)  
210.826.4864 (f)

Alamo Family Foot and Ankle Care

New Patient Form

## Personal Information

Patient's Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Social Security Number: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Emergency Contact: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

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## Employment Information

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (    ) \_\_\_\_\_

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How did you hear about our office?

Google/Internet  Insurance list  Yellow Pages  Tex-Med

Friend/Family Member  Doctor/Clinic: \_\_\_\_\_

Please provide name of clinic or doctor



Indicate **if your family has a history** of these medical problems:

- Heart Disease     High Blood Pressure     Diabetes     Cancer
- High Cholesterol     Bleeding Disorders    Other: \_\_\_\_\_

Indicate **if you suffer** from these medical problems:

- Diabetes     High Blood Pressure     Thyroid Disease     Heart Disease
- Asthma     Bleeding Disorders     Mitral Valve Prolapse     Pacemaker
- Heart Burn     Liver Disease     UTI     Blood Clots
- Gout     Osteoarthritis     Rheumatoid Arthritis     Seizures
- Neuropathy     Anemia     Anxiety     Depression
- Osteoporosis     Kidney Disease     High Cholesterol     Cancer

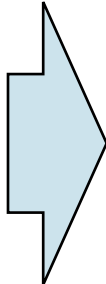
Other medical problems: \_\_\_\_\_

Indicate if you have suffered from any of these symptoms in the last 6 months:

- Constitution:  Weight Loss     Changes in \_\_\_\_\_     Leg Cramps
- Eyes:  Blurred vision     Eye Glasses     Cataracts
- Head:  Hearing problems     Headache     Hoarseness
- Cardiovascular:  Chest Pain     Palpitations     Heart Attack
- Pulmonary:  Shortness of Breath     Cough     Wheezing
- Skin:  Rashes     Ulcers     Masses
- Endocrine:  Heat Intolerance     Cold Intolerance     Hair Loss

Other: \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, to be made to: Alamo Family Foot Care, PA.  
 I Herby give permission to the physicians of Alamo Family Foot Care, PA to examine, administer treatment and perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.  
 I Hereby acknowledge the receipt of the privacy practices (Health Information and Portability Act) of Alamo Family Foot Care, PA.



**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Name and address of your preferred pharmacy:** \_\_\_\_\_