WELCOME TO OUR OFFICE

Complete the following information for your case history file. (PLEASE PRINT)

Today's Date: _____

Patient Name: _____

Sex: ☐ Male ☐ Female Social Security Number: _____

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: _____ Cell Phone: _____

Which phone number would you like us to use when we call you for appointments or medical information?
☐ Home ☐ Cell ☐ Work

Home Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Occupation: _____ Business Phone: _____

Spouse's Name: _____ Date of Birth: _____

Social Security Number: _____ Occupation: _____

Spouse's Employer: _____ Business Phone: _____

Business Address: _____

Name of Contact in Case of Emergency: _____ Phone: _____

Address: _____ Relationship: _____

Primary Medical Insurance: _____

Name of Insured: _____

Secondary Medical Insurance: _____ Name of Insured: _____

Family Physician: _____ Phone #: _____

Who may we thank for referring you to our office or how did you find out about our office?

_____

I hereby give Dr. Derek Hindman and/or Dr. Elizabeth Doriott permission to administer treatment and perform such procedures as may be necessary for the diagnosis and treatment of my foot and /or ankle condition. Also, I authorize the release of any medical information necessary to process my claim. I also authorize payment to Dr. Hindman and/or Dr. Doriott and authorize him/her to keep my other medical care providers informed of my medical information, progress and treatment obtained. I understand as a courtesy, Better Foot Care and/or Better Family will file all insurance claims for me and I am ultimately responsible for payment of all services rendered.

Signature: _____ Date: _____

BETTER FOOT CARE
Dr. Derek C. Hindman, DPM

BETTER FAMILY CARE
Dr. Elizabeth A. Doriott, DO

11465 Springfield Pike • Cincinnati, OH 45246 • 513-671-2555 • Fax 513-671-0135

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

Why are you seeing the doctor? _____

_____

_____

Have you been treated for this before: ☐ Yes ☐ No

What was done: _____

Previous Doctor: _____

Are you currently under Physician's care: ☐ Yes ☐ No

For what? _____ Date Last Seen: _____

FAMILY HISTORY: (List Type / Person / Age)

☐ Cancer: _____

☐ Diabetes: _____

☐ Heart Attack/Stroke: _____

☐ High Blood Pressure: _____

☐ Other: _____

SOCIAL HISTORY:

Tobacco (ppd): _____ Caffeine (cpd): _____

Alcohol: _____ Activities: _____

PAST MEDICAL HISTORY:

☐ Cancer _____ ☐ Diabetes _____ ☐ High Blood Pressure _____

☐ Bleeding Disorders _____ ☐ Anemia _____ ☐ Stomach Ulcers _____

☐ Gout _____ ☐ Heart Problems _____ ☐ Stroke _____

☐ High Cholesterol _____ ☐ Thyroid Disease _____ ☐ Kidney Disease _____

☐ Other: *explain* _____

PAST SURGERIES/HOSPITALIZATIONS:

Condition/Date: _____

_____

MEDICATIONS: ☐ No ☐ Yes, please list below.

_____ _____

_____ _____

_____ _____

ALLERGIES: ☐ No ☐ Yes, please list below.

_____

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