Phone: 423-764-2299
Fax: 423-968-3340
2765 West State Street Bristol, TN 37620
616 Campus Drive, Ste 300 Abingdon, VA 24210

Patient Information Form

Name: First:_______________________________ Middle:________________ Last: _______________________________

Sex: □Male □Female Social Security #: ____________________________ Date of Birth: _________________________

Email: ____

Street Address:____

City: ____ State: _________________________ Zip: ____________________

Employment status (employed, retired, disabled, student…): ____

Home Phone: ___________________________________ Work Phone: ____

Cell Phone: _____________________________________

Who is your Primary Care Physician? ____

Date last seen by Primary Care Physician: ______________ Did he/she refer you here? ___________________________

If not referred, how did you hear about Highland Podiatry? ____

Emergency Contact:____ Phone:___________________________________

Marital Status: __________________________________

Primary Language:
- □ English
- □ Spanish
- □ Other:__________________

Contact Preference:
- □ Phone
- □ Mail
- □ Email

Race:
- □ Not Specified
- □ Black/African American
- □ White
- □ Asian
- □ American Indian/Alaska native
- □ Hawaiian/Pacific islander

Leave a message with:
- □ Patient Only
- □ Patient and/or Spouse
- □ Anyone Answering Phone

Ethnicity:
- □ Not Specified
- □ Hispanic or Latino
- □ Not Hispanic or Latino

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Patient Name: ______________________________

Please list all medications you are taking (you may use the back of this form if needed):

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Please list all medications you are allergic to and the reaction you had (you may use the back of this form if needed):

__________________________ _________________________ ___________________________

Are you allergic to any of the following?
□ Tape □ Latex

Smoking Status: Height: ___________ Weight: _________lbs
□ Current every day Smoker
□ Current some day Smoker
□ Smoker, current status unknown
□ Former Smoker
□ Never Smoker
□ Unknown, If Ever Smoked

Please indicate if you have any of the following conditions

Arthritis

□ Osteoarthritis
□ Rheumatoid
□ Gout
□ Other Sero-negative Disorder

Gastrointestinal
□ Acid Reflux
□ Bowel Disorders
□ GI/Rectal Bleeding
□ Hiatal Hernia
□ Stomach Problems
□ Ulcers

HEENT
□ Headache
□ Eye Problems
□ Hearing Problems

Psychological
□ Anxiety
□ Alcohol Dependence
□ Depression
□ Drug Dependence

Major Disease
□ Angina
□ Arrhythmia
□ Chest Pain
□ Diabetes
□ Heart Disease
□ Heart Attack
□ Hypertension
□ Mitral Valve Prolapse
□ Stroke

Miscellaneous
□ Bladder Problems
□ Cancer History
□ Epilepsy
□ Hepatitis
□ Kidney Problems
□ Muscle Disease
□ Skin Conditions
□ Thyroid Disease

Respiratory
□ Asthma
□ Bronchitis
□ Emphysema
□ Frequent Colds
□ Lung Disease
□ Shortness of Breath
□ Tuberculosis

Vascular
□ Anemia
□ Bleeding Disorder
□ Blood Clots
□ Leg Pain w/walking
□ Leg Ulcerations
□ Night Cramps
□ Poor Circulation
□ Swelling/Phlebitis

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□ Transfusions □ Vein Problems

Insurance Information

Primary Coverage:

Insured name: ______________________________________ Relation to Patient: ______________________________

Date of Birth: _______________________________________ Social Security #: ________________________________

Insured Address: ____

Home/ Cell Phone: __________________________________ Work Phone: ____________________________________

Insurance Carrier: ___________________________________ Employer: _______________________________________

Secondary Coverage:

Insured name: ______________________________________ Relation to Patient: ______________________________

Date of Birth: _______________________________________ Social Security #: ________________________________

Insured Address: ____

Home/ Cell Phone: __________________________________ Work Phone: ____________________________________

Insurance Carrier: ___________________________________ Employer: _______________________________________

Responsible Party Information for Minor Children:

For billing and collections purposes, the parent who signs the consent bears financial responsibility for incurred charges. We need the following information for that person:

Name: First:_______________________________ Middle:________________ Last: _________________________________

Address:____

Social Security #: ____________________________ Date of Birth: __________________________

Email: ____

Home Phone: ____________________________________ Work Phone: ____

Cell Phone: ______________________________________ Other Phone: ____

Employment status (employed, retired, disabled, student…): ____

Employer Name: _____________________________________ Phone: _______________________________________

Address: ____

Occupation: ____