FootCare Center of
Santa Clarita / Moorpark
Robert J. Abrams, D.P.M.

Date: ______________

First Name____________________ Middle________Last Name __________________

Social Security # _______________ Date of Birth__________ Age ___ Gender______

Address __________________________ City _____________ Zip code___________

Home # ________________ Work #___________________ Cell#_______________

Primary Physician __________________Date last Seen________________________

Phone #______________________________ Fax #____________________________

Emergency Contact_______________________ Phone #________________________

*****This Information is Federally Mandated*****

Primary Language________________Race_____________ Ethnicity___________

Anyone 13 yrs of age or older must answer: Smoke? Yes or No

How Much?________________

How did you hear about our office: (Please check one)
□ Internet □ Magazine □ Physician □ Phonebook □ Patient □Insurance Other:_______

Marital Status ____________ Student Status__________ Employer________________

Primary
Insurance:____

Policy Holder:____________________ Relationship:____________________________

D.O.B. _________________________ S.S.#____________________________________

Policy ID#______________________ Group#________________________________

Secondary
Insurance:____
Policy Holder: ______________________Relationship:_________________________
D.O.B.__________________________ S.S.# __________________________________
Policy ID# ________________________ Group#_______________________________

Pre-History

1. State in your words your medical reason(s) for coming to our office:

____

____

2. Please list all medications you are taking: ______________________

____

____

3. For Women Only: Are you pregnant? ____ If so, how many months? ________

Family History

4. Indicate which of your immediate relatives have had any of the following diseases:

Cancer__________________________ Diabetes ________________________

Heart Trouble ____________________ High Blood Pressure _______________

Kidney Disease __________________ Mental/Emotional Disease___________

Stroke __________________________ Arthritis_________________________

5. Please check if you have any of the following problems:

____ Recent Weight Loss
____ Headaches
____ Trouble with Vision
____ Trouble with Hearing
____ Allergies /Hay Fever
____ Asthma
____ Thyroid
____ Diabetes
____ Skin
____ Anemia
____ Heart
____ Mitral Valve Prolapse
____ Heart Murmur
____ Circulation
____ High Blood Pressure
____ Chest Pain
____ Lungs (Pneumonia, TB)
____ Swelling in Feet or Ankles
____ Arthritis
____ Kidney Disease or Stones
____ Gout
____ Bleeding Tendency
____ Scarring Tendency
____ Joint pain or Stiffness
____ Numbness in Feet or Legs
____ Cramps in Feet or Legs
____ Low Back Pain
____ Do you smoke? How much? _________
____ Do you drink alcohol? How much? ______
____ Psychiatric
____Fainting or Convulsions
____Strokes
____Pain in other areas
____ Other Illnesses or Problems
____ Shortness of Breath (Cough, Pleurisy, Wheezing)
____ Liver Disease, Gall Bladder Disease (or Jaundice)
____ Stomach Trouble

Allergic To: ____ Penicillin ____ Sulfa ____ Codeine ____ Aspirin____

____ Novocain ____ Tape ____ Other____________ None _____

I hereby authorize the release of any information including the diagnosis and treatment records to my insurance company. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled. I authorize treatment recommended by Dr. Robert J. Abrams.

Signature: ______________________Signature of Parent:____________________

(if patient is a minor)