Flagstaff Foot & Ankle Specialists

Dr. Edward L. Wiebe
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NEW PATIENT FORM

Name: _____ Sex: ☐ M ☐ F Date of Birth:_____

Age:_____ Email: _____

Social Security No:_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ Shoe Size: _____

Family Physician (PCP-Primary Care Physician): _____

Who may we thank for your referral? _____ Spouse's Name: _____

INSURANCE INFORMATION (Please provide us with a copy of your card)

Primary Insurance: _____ ID #: _____ Group #: _____

Primary Insured: _____ Primary Insured Birth Date and relations: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Secondary Insured: _____ Secondary Insured Birth Date and relations: _____

Are your injuries accident related? ☐ Yes ☐ No Did you sustain an injury at work? ☐ Yes ☐ No

If so, when?_____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

List any treatment, tests or X-ray's you have had for this problem: _____

Medication/Supplement (if you have a list please provide)	Dose	Times / Day	How Long

Allergies: _____

Current Medical Problems: _____

_____

PAST MEDICAL HISTORY

Surgeries/ Hospitalization:	Year	Reason

Have you ever had general anesthesia? ☐ Yes ☐ No Have any problems with anesthesia? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your: (describe all YES responses)

Eyes	☐ Yes	☐ No	_____
Ear, Nose, Throat	☐ Yes	☐ No	_____
Lungs, Breathing	☐ Yes	☐ No	_____
Digestion/Reflux	☐ Yes	☐ No	_____
Bowel movement	☐ Yes	☐ No	_____
Bladder problem	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Bleeding problems	☐ Yes	☐ No	_____
Balance problems	☐ Yes	☐ No	_____
Numbness/tingling	☐ Yes	☐ No	_____
Chest Pain	☐ Yes	☐ No	_____
Psychological problems	☐ Yes	☐ No	_____
AIDS	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Polio	☐ Yes	☐ No	_____
TB	☐ Yes	☐ No	_____
Epilepsy	☐ Yes	☐ No	_____

FAMILY HISTORY

Any major medical problems (grandparents, parents, etc.) If so, who and what? _____

_____

_____

SOCIAL HISTORY

☐ Work in the home ☐ Employed (occupation) _____ ☐ Student

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Children ☐ No ☐ Yes No of children: _____ Do you live alone: ☐ No ☐ Yes

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise / hobbies? _____

Are you on a special diet? ☐ No ☐ Yes Describe: _____

History of substance abuse? ☐ No ☐ Yes Describe: _____

Do you currently smoke? ☐ No ☐ Yes _____ packs per day for _____ years

Have you quit smoking? ☐ This year ☐ 1 year ☐ 5 years ☐ 10 years

Previously smoked? _____ packs per day for _____ years

Drink alcohol? ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ 1-2x/year ☐ None at all

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature: _____ Date: _____

Parent (if minor) or Guardian: _____ Date: _____

Reviewed by: _____ DPM Date: _____