Flagstaff Foot & Ankle Specialists

Dr. Rachel O'Connor, DPM
8 W. Columbus Ave, Flagstaff, AZ 86001
(928) 226-7555 (phone)/(928) 226-0014 (fax)

NEW PATIENT FORM

Name:_____ Sex: ☐ M ☐ F Date of Birth:_____
Age:_____ Email:_____
Social Security No:_____ Preferred Pharmacy:_____
Mailing Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Height:_____ Weight:_____ Shoe Size:_____
Family Physician (Primary Care Physician):_____
Who may we thank for your referral?_____ Spouse's Name:_____

INSURANCE INFORMATION

Primary Insurance:_____ ID#:_____ Group#:_____
Primary Insured:_____ Primary Insured Birth Date and relation:_____
Secondary Insurance:_____ ID#:_____ Group#:_____
Secondary Insured:_____ Secondary Insured Birth Date and relation:_____
Work related injury/worker's compensation: ☐ Yes ☐ No

CHIEF COMPLAINT

Why are you seeing the doctor today:_____
List any previous treatment, test or x-rays 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 (parents, grandparents, 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

Type of exercise:_____

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? ☐No ☐Yes How long ago? _____ Previously smoked_____ packs per day for_____years

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

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:_____