PATIENT INFORMATION
(PATIENTS UNDER AGE 18)

Name: _____ Date of Birth _____
Patient SS# _____ Male _____ Female _____ Phone _____
Patient Age _____ Height _____ Weight _____ Shoe Size _____
Patient Street Address _____ City _____ State _____ Zip _____
Patient Mailing Address _____ City _____ State _____ Zip _____

Father's Name _____ Date of Birth _____ SS# _____
Address (if different) _____ Phone _____
Employment _____ Phone _____

Mother's Name _____ Date of Birth _____ SS# _____
Address (if different) _____ Phone _____
Employment _____ Phone _____

Responsible Party _____
Address _____ Phone _____

Patient's Physician _____ Date of last visit _____
If referred to us, who may we thank? Physician _____
Another patient _____ Phone Book _____ Other _____

What kind of foot problem/s are you having? _____

Please check any of the following that apply:
(1). Are you subject to prolonged bleeding? Yes _____ No _____
(2). Is there any family history of diabetes? Yes _____ No _____
(3). Are you a diabetic on insulin or medication? Yes _____ No _____
(4). Please list all allergies to medications: _____

Have you been treated for: Heart trouble _____ Asthma _____
Glaucoma _____ Rheumatic fever _____
Liver trouble _____ Kidney trouble _____
Hepatitis _____ High Blood Pressure _____
Have you tested HIV positive or do you have aids? _____

I understand that payment is expected at the time of service unless otherwise agreed.

_____
Parent's Signature

I Hereby give my permission for medical treatment by
Dr. John D. Wright.

_____ _____
Parent's Signature Date