BABAJIDE OGUNLANA, DPM, PLLC

West Houston Foot & Ankle Center

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HELLO AND WELCOME TO OUR OFFICE! THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND FOR YOUR HEALTH.

PATIENT INFORMATION -CONFIDENTIAL

Patient's Name _____ Date of Birth_____ Age _____

Home Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Work Address _____Work Phone_____

Social Security Number _____ Driver's License _____

Sex ☐ Female ☐ Male Marital Status **M S D W** Spouse/Parent/Guardian Name _____

Emergency Contact _____ Phone Number _____

INSURANCE/RESPONSIBLE PARTY INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Policy ID		
Group #		
Policy Holder's First Name		
Policy Holder's Last Name		
Policy Holder's SS#		
Policy Holder's Date of Birth		
Patient's Relationship to Policy Holder	☐ Self ☐ Spouse ☐ Child ☐ Other _____	☐ Self ☐ Spouse ☐ Child ☐ Other _____
Policy Holder's Gender		
Policy Holder's Address, City, Zip		
Claims Mailing Address		
Phone #		

PLEASE TURN TO THE NEXT PAGE

MEDICAL INFORMATION

Name of Family Physician _____

Present Foot Problem

- ❑ Ingrown toe nail
- ❑ Bunion
- ❑ Injury
- ❑ Heel Pain
- ❑ Hammer Toes
- ❑ Foot/Nail Care
- ❑ Skin Condition
- ❑ Diabetic Foot Care
- ❑ Orthotics
- ❑ Other Explain _____

How is your general health? ☐ Good ☐ Fair ☐ Poor

Are you taking any medications at present? ☐ Yes ☐ No If yes what? _____

_____

Have you ever experienced any allergic reactions or adverse effects from any of the following?

- ❑ Penicillin
- ❑ Novocaine
- ❑ Local anaesthetics
- ❑ Sulfa Drugs
- ❑ Aspirin
- ❑ General Anaesthetics
- ❑ Tape
- ❑ Cortisone
- ❑ Other antibiotics
- ❑ Codeine
- ❑ Latex-Rubber
- ❑ Other pain medications
- ❑ Dyes/Iodine
- ❑ Other_____
- ❑ Non-steroidal medications

Do you have or have you ever you ever had any of the following: (Check if yes)

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Ankle/Leg Swelling
- ❑ Any Heart Troubles
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Blood Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain
- ❑ Diabetes
- ❑ Difficulty Healing
- ❑ Emphysema
- ❑ Epilepsy/Seizure
- ❑ Foot Ulcer
- ❑ GI or Rectal Bleeding
- ❑ Gout
- ❑ Hearing Problem
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Kidney Problems
- ❑ Leg Cramps
- ❑ Leg Ulceration
- ❑ Liver Problems
- ❑ Low Back Pain
- ❑ Multiple Sclerosis
- ❑ Night Cramps
- ❑ Phlebitis/Calf Pain
- ❑ Poor Circulation
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sickle Cell
- ❑ Skin Conditions
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Weak Ankles
- ❑ Other _____ _____ _____

Please list all previous Injuries _____

Please list all previous Surgeries _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Cigarettes / Pipe / Cigar Amount per day _____ # years _____ Quit Date _____

Do you drink alcohol? ☐ Yes ☐ No Type_____ Amount per day _____ # years _____ Quit Date _____

Recreational Drugs? ☐ Yes ☐ No Type_____ Amount per day _____ # years _____ Quit Date _____

How did you hear about our office? (Please give names)

☐ Friend: _____ ☐ Yellow Pages Other: _____

☐ Doctor: _____ ☐ Newspaper: _____

CONSENTS

⇒ I hereby give WEST HOUSTON FOOT & ANKLE CENTER: Dr. Babajide Ogunlana permission to examine and treat my feet. I agree to be responsible for all medical bills.

⇒ In consideration of services rendered, I hereby authorize and direct all insurance company(ies) under which I am insured to pay directly to the doctors all benefits due under said policy(ies) by reason of services rendered therein.

⇒ Each person signing this consent is financially responsible for charges not collected by this assignment.

⇒ All professional services rendered are charged to the patient. It is customary to pay for services rendered unless other arrangements have been made in advance with the office administrator.

Patient/Parent/Guardian's Signature _____ Date _____