



All Pro Foot and Ankle
Dr. Ankita Patel, DPM

www.apfootandankle.com

700 2nd Street, Suite E
Swedesboro, NJ 08085-1138
P: (856) 412-8005
F: (856) 886-4172

NEW PATIENT PAPERWORK – PLEASE PRINT!

PATIENT INFORMATION

First Name:		MI:	Last Name:	
DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Address:		
City:	State:	Zip:	Home Tel:	
Work Tel:	Cell:	Email:		

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name:	Physician Phone #:
Physician Address:	Date of Last Visit:

PHARMACY INFORMATION

Pharmacy Name :	Pharmacy Phone #:
Pharmacy Address:	

EMERGENCY CONTACT

Emergency Contact Name:	Phone #:
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	

RELEASE OF PERSONAL INFORMATION TO PATIENT'S DESIGNEES

I authorize medical staff members of this practice to discuss medical history, diagnosis, treatment, and prognosis with other medical providers and organizations that participate in care and with those listed below

Name	Phone Number	Relationship

CONSENT TO TREATMENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature:	Guardian Signature (if under 18 y.o.):	Date:

REASON FOR VISIT: _____

HOW DID YOU HEAR ABOUT US? Doctor Referral Insurance Friend/Family Internet/Google

Referred by: _____ Other _____



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MEDICAL HISTORY

	Yes		Yes		Yes
Cardiovascular		Endocrine		Neurologic	
High blood pressure		Type I diabetes		Peripheral neuropathy	
Peripheral artery disease		Type II diabetes		Stroke history	
High cholesterol		Thyroid disorders		Multiple sclerosis	
Heart disease		Cushing’s syndrome			
Rheumatologic/Autoimmune		Musculoskeletal		Infectious	
Gout		Osteoarthritis		Cellulitis or skin infections	
Rheumatoid arthritis		Osteoporosis		Athlete’s foot	
Lupus		Previous fractures		Fungal toe infection	
Psoriatic arthritis		Sciatica		Bone infection	
Dermatologic		Metabolic		Vascular	
Eczema		Chronic kidney disease		Deep vein thrombosis (DVT)	
Psoriasis		Liver disease		Blood clots	
Calluses, corns, or foot ulcers				Cold, pale fingers or toes	

Other problems not listed above:

SURGICAL AND HOSPITALIZATION HISTORY (Please list all surgeries and hospitalizations)

SOCIAL HISTORY

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other			
Do you drink alcohol regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Drinks/Week:	
Do you or did you smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, packs per day?	Stop Date:
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military <input type="checkbox"/> Student			
Occupation:	Employer:	City:	

FAMILY HISTORY (check if anyone in your family has or had the following)

	Mother	Father	Siblings	Children	Other Relative
Cancer					
Diabetes					
Heart Disease					
Arthritis					
Osteoporosis					

MEDICATIONS

Medication name and strength	Medication name and strength
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES (please list)

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VITAL SIGNS AND MEASUREMENTS

Height:	Weight:
Blood Pressure:	Shoe Size: