

**Affiliated Foot & Ankle, P.C.**

**PATIENT UPDATE**

**Please Fill in Completely**

**Today's Date:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Primary phone #:** \_\_\_\_\_ **Secondary phone #:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Shoe Size:** \_\_\_\_\_

**Home Address** \_\_\_\_\_

Street Apt. #

City State Zip

**Insurance**

**Primary** Insurance Name Policy Holder/ DOB Policy Number

**Secondary** Insurance Name Policy Holder/ DOB Policy Number

**Medical**

**What is the primary reason for your visit today?** \_\_\_\_\_

**Medical History:** \_\_\_\_\_

**Surgical History and Hospitalizations:**

**Medications/ Please Attach List if available:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Family Medical History:**

**Mother's Medical Conditions:** \_\_\_\_\_

Living: \_\_\_\_\_ Deceased: \_\_\_\_\_

**Father's Medical Conditions :** \_\_\_\_\_

Living: \_\_\_\_\_ Deceased: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

First Name Last Name Date of Last Appt. with PCP

**If you have diabetes:** \_\_\_\_\_

Last Hemoglobin A1c Last fasting blood glucose

**Emergency Contact/ Phone #** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**