MICHAEL A. GARVIN, D.P.M., P.A.

WELCOME BACK:
PLEASE TAKE A MOMENT AND UPDATE YOUR INFORMATION. THANK YOU.

PLEASE PRINT CLEARLY:

DATE: _____ HEIGHT: _____ WEIGHT: _____

NAME: _____
(FIRST) (MI) (LAST)

ADDRESS: _____

_____
(CITY) (STATE) (ZIP)

HOME PHONE: _____ CELL: _____ WORK: _____

HAS YOUR INSURANCE COMPANY CHANGED? ____ YES ____ NO DO YOU SMOKE? ____ YES ____ NO

PRIMARY PHYSICAN: _____ DATE LAST SEEN: _____

ALLERGIES: _____
(WRITE N/A IF NO CHANGES)

CURRENT MEDICATIONS: _____
(WRITE N/A IF NO CHANGES)
_____

SURGERIES SINCE LAST VISIT: _____
(WRITE N/A IF NO CHANGES)
_____

HOSPITALZATIONS: _____
(WRITE N/A IF NO CHANGES)

TO WHOM MAY WE RELEASE YOUR PROTECTED HEALTH INFORMATION:
NAME: _____ RELATIONSHIP: _____
PHONE: _____
NAME: _____ RELATIONSHIP: _____
PHONE: _____

WHAT IS YOUR FOOT COMPLAINT TODAY? _____
PLEASE SIGN _____