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

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

DATE: _____

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

ADDRESS: _____

_____
(CITY) (STATE) (ZIP)

CELL: _____ HOME PHONE: _____ WORK: _____
(CIRCLE WHICH ONE YOU PERFER US TO CALL)

PLEASE GIVE THE FRONT DESK YOUR NEW INSURANCE CARD

RACE: CAUCASIAN OR WHITE ___ BLACK OR AFRICAN AMERICAN ___ NATIVE HAWAIIAN OR PACIFIC ISLANDER___ AMERICAN INDIAN OR ALASKAN ___ ASIAN ___HISPANIC OR LATINO ___ OTHER _____

MARITAL STATUS: MARRIED ___ SINGLE ___ DIVORCED ___ WIDOW ___ OTHER _____

DO YOU SMOKE: YES FORMER NO ALCOHOL: NONE / RARELY / MODERATELY / DAILY / QUIT

SEX: F M ARE YOU PREGNANT: YES NO HEIGHT: _____ WEIGHT: _____

WHAT PHYSICIAN TREATS YOU FOR DIABETES? _____

WHAT PHYSICIAN PRESCRIBES YOU BLOOD THINNER? _____

WERE YOU REFERRED BY A PHYSICIAN? NAME: _____ PHONE: _____

YOUR EMAIL ADDRESS: _____

PRIMARY PHYSICAN: _____ PHONE: _____

ALLERGIES: _____

_____

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

_____

_____

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

EMERGENCY CONTACT:
NAME: _____ RELATIONSHIP: _____ PHONE: _____

PHARMACY NAME: _____ PHONE: _____
ADDRESS: _____

CURRENT MEDICATIONS: _____
(MUST HAVE MILLIGRAMS AND YOU CAN GIVE US A LIST INSTEAD OF WRITING IT DOWN)

_____

_____

_____

_____

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PLEASE SIGN _____