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GARY S. McCARTER, D.P.M.
DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
SURGERY, DISEASES, AND INJURIES OF THE FOOT

Newport Superior Medical Plaza
1501 Superior Ave., Suite 110
Newport Beach, CA 92663

Welcome To Our Office

Please print and complete the following information for your case history file

Today's Date _____

Last Name	First	Middle Initial	Birth Date	Age

Residence Address	City	State	Zip	Marital Status
				Single ☐ Married ☐ Widowed ☐ Divorced ☐

Billing Name and Address (if different than above)

Home Phone	Work Phone	Social Security #	Cell Phone

Name of Employer	Occupation	Work Address	Zip

Spouse 's Name, Employer and Work Number

Name, address and phone of contact in case of emergency | Relationship

If other than patient, name and address of person responsible for this account

Whom may we thank for referring you? | Directory?

Do you have medical insurance? ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.	Group No.

Is it through your employer? ☐ Yes ☐ No	Is there secondary ins. (spouse, medicare, etc.?) ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.

List any medical conditions you have (allergies, impairments, etc.)

Name of family physician	Phone	Are you currently under your physician's care? ☐ Yes ☐ No

If yes, for what | May we contact your physician for your health records? ☐ Yes ☐ No

Have you had previous treatment by a Podiatrist? ☐ Yes ☐ No	When:	For What:

My chief foot complaint is *(for more space use back of form)*:

This condition(s) has existed for:	Days	Weeks	Months	Years

What medicines do you take regularly?

Do you have or have you had any of the following: (*do not know)

	Yes	No	*DNK
Foot or Leg Injuries	☐	☐	☐
Foot or Leg Surgery	☐	☐	☐
Foot or Leg Cramps	☐	☐	☐
Foot or Leg Numbness	☐	☐	☐
Knee Pain	☐	☐	☐
Low Back Pain	☐	☐	☐
Diabetes	☐	☐	☐
Heart Trouble	☐	☐	☐
Stroke	☐	☐	☐
Epilepsy	☐	☐	☐
Liver Disease	☐	☐	☐
Kidney Disease	☐	☐	☐

	Yes	No	*DNK
Rheumatic Fever	☐	☐	☐
High Blood Pressure	☐	☐	☐
Polio	☐	☐	☐
Bursitis	☐	☐	☐
Stomach Ulcers	☐	☐	☐
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Pneumonia	☐	☐	☐
Bronchitis	☐	☐	☐
Thyroid Disease	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	*DNK
Gout	☐	☐	☐
Fainting Spells	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Blood Disease	☐	☐	☐
Circulation Problems	☐	☐	☐
Hardening of Arteries	☐	☐	☐
Varicose Veins	☐	☐	☐
Alcoholism, Substance Abuse	☐	☐	☐
Cancer	☐	☐	☐
Prone to Infection	☐	☐	☐
Do you smoke	☐	☐	☐

Are you allergic to or sensitive to

	Yes	No	*DNK
Novocaine	☐	☐	☐
Other Anesthetics	☐	☐	☐
Penicillin	☐	☐	☐
Adhesive Tape	☐	☐	☐
Materials	☐	☐	☐
Drugs	☐	☐	☐
Foods	☐	☐	☐

Other Illnesses _____

List any operations or blood transfusions

I hereby give Dr. _____ permission to examine patient.

Patient's Signature _____