Name: ______________________ SS# ______________

Date of Birth: ______________ Age: ______________ Home Phone #: ______________

Cell #: ______________________ E-Mail: ______________________

Address: ____

City ______________________ State: ______________ Zip: ______________

Would you like to participate in the patient portal? ❑ Yes ❑ No

PLEASE CIRCLE: Female / Male Married / Single / Other

Race: White / American Latino / Asian / African American / Other: ______________

Ethnicity: Hispanic or Latino - Not Hispanic or Latino

Primary Language: ______________________

Employed By: ______________________ Occupation: ______________________

Business Phone ______________ Address ______________________

City: ______________________ State ______________ Zip: ______________

PHARMACY: ______________ /Phone: ______________ /Address: ______________

Primary Care Physician: ______________________ Phone: ______________

Please List any specialists currently treating you:

Specialist: ______________ Phone #: ______________ Specialty: ______________

Specialist: ______________ Phone #: ______________ Specialty: ______________

In Case of an Emergency, whom may we contact?

Relationship: ______________________ Phone Number: ______________

Whom May We Thank for Referring You? ______________________

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE. TO ASSIST IN THE COORDINATION OF MY CARE, I HEREBY GIVE WRITTEN CONSENT TO THE DOCTORS OF FAMILY FOOT HEALTH CENTER, PC TO VIEW MY PRESCRIPTIONS HISTORY PROVIDED THROUGH ELECTRONIC HEALTH RECORD EXCHANGE
I hereby give FFHC permission to examine & treat.

SIGNATURE ______________________ DATE ______________
Parent/Guardian/POA