Trang Thu Nguyen, D.P.M., P.A.

1144 N. Plano Rd. Ste. 230, Richardson, TX 75081 Office: 972-231-3122 | Fax: 469-519-2120

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: ___________________________ First Name: _________________________ M.I.: __

Address: ____

City: ________________________________ State: ________________ Zip Code: ___________

Phone #: ______________________________ Social Security #: __________________________

Date Of Birth: ____________________ Age: _____ Sex: _____ Marital Status: _____________

Employer Name And Address: ____

____ Work Phone #: __________________

Emergency Contact Name: ______________________________ Phone #: _________________

INSURANCE INFORMATION: (Please allow staff to photocopy your insurance ID card)

Insurance Company _____________________________ Insured's Date Of Birth: ____________

Plan Name: ______________________________ Insured's Name: _________________________

Policy / ID#: _________________________________ Group #: ____________________________

Claims / Customer Service#: ______________________________

MEDICAL INFORMATION

1. Describe present foot problems (specify left, right, or both feet): ____________________

   ____

2. Former Podiatrist: ____
3. Family Physician: ____
4. How did you know about Dr. Nguyen? ____
5. Are you in good general health? YES ____ NO ____
6. PAST MEDICAL HISTORY: (Circle all that apply)

AIDS/HIV Anemia Alzheimer's Cancer: _____________ Coronary Artery Disease Dementia Diabetes: Type I Type II Edema (swelling) Fibromyalgia Gout	Heart Attack Hepatitis (A,B,C) Hypertension Kidney Disease -Chronic Kidney Failure? Y/N -Dialysis Patient? Y/N Lung Disease (COPD, Asthma, Emphysema) Multiple Sclerosis Osteoarthritis	Parkinson's Phlebitis Poor Circulation/PVD Rheumatic Fever Rheumatoid Arthritis Seizures Stroke Stomach Ulcer Tuberculosis

Other Medical History not listed above: ____

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7. PAST SURGERIES: ____

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8. PAST HOSPITALIZATIONS: ____

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9. FAMILY MEDICAL HISTORY: ____

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10. SOCIAL HISTORY: Tobacco use ________ Alcohol ________ Recreational drugs _______ Type of work ___________ Marital status _______________ Children _______

11. MEDICATIONS PRESENTLY TAKEN: _____________________________________

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12. ALLERGIES: ____

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Patients are expected to pay for professional services as they are received, **unless** special and specific arrangements are made. I hereby give my consent to Dr. Trang T. Nguyen to perform such procedures as may be deemed necessary for diagnosis and/or treatment of my foot condition(s) or any other conditions associated therewith.

____ ____________________

Patient’s Signature or Parent’s (if minor child) Date