

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

Cottonwood Medical Center

100 S. Cottonwood Drive, Ste. A, Richardson, TX 75080 Office: (972)231-3122 Fax: (972-)231-2021

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

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Employer Name and Address: _____

_____ Work Phone #: (_____) _____ - _____

Emergency Contact Name: _____ Phone #: (_____) _____ - _____

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

PRIMARY INSURANCE: Insured's Date of Birth: _____

Plan Name: _____ Insured's Name: _____

Policy / ID #: _____ Group #: _____

Claims Address: _____

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

Other Medical History not listed above: _____

7. PAST SURGERIES: _____

8. PAST HOSPITALIZATIONS: _____

9. FAMILY MEDICAL HISTORY: _____

10. SOCIAL HISTORY: Tobacco use _____ Alcohol _____ Recreational drugs _____

Type of Work _____ Marital Status _____ Children _____

11. MEDICATIONS PRESENTLY TAKEN: _____

12. ALLERGIES: _____

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 the 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: _____

Physician's Signature

Date: _____