

Bruce A. Scudday, DPM, FACFAS

1700 Curie Drive, Suite #4000
El Paso, TX 79902

1400 George Dieter, Suite #230
El Paso, TX 79936

Patient's name _____ **Date of birth** _____
Last First MI

Mailing/Physical address _____

City _____ **State** _____ **ZIP** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Sex (M / F) **Marital Status: S M D W Separated** **Social Security #** _____

Patient Employer _____ **Occupation** _____

Business Address _____

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if applicable) _____

How did you hear about Dr. Scudday? _____

Emergency Contact: _____ **Phone** _____

If the insurance is in the name of another person (such as a spouse or parent), please provide the following information:

Guarantor's Name _____ **Guarantor's SS#** _____
Last First MI

Mailing address _____

City _____ **State** _____ **ZIP** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Guarantor Date of Birth _____

Guarantor's Employer _____ **Occupation** _____

Business Address _____

I acknowledge a copy of the Notice of Privacy Practices was made available to me. I am entitled to take a copy of this Notice if I desire to do so.

Your Signature _____

Patient's Name _____ Chart # _____

What problem can we help you with today? _____

Is this problem, illness or injury the result of an accident or is it work related?.....YES NO

Are you in good health now?.....YES NO

Are you currently under the care of a physician?.....YES NO

If so, what is the condition being treated? _____

Have you ever been hospitalized or had a serious illness?.....YES NO

If yes, explain _____

Have you ever had surgery?.....YES NO

If yes, explain _____

(Women) Are you pregnant?.....YES NO

If so, what is your due date? _____

Do you use tobacco in any form?.....YES NO

If yes, what type and how much? _____

Do you use alcohol?.....YES NO

If yes, how much and how often? _____

Are you ALLERGIC to any medications?.....YES NO

If yes, please list _____

If you are taking any medications, please list the name and dosage below:

Do you have or have you ever had any of the following?

Stroke.....YES NO

Congestive heart failure.....YES NO

Diabetes.....YES NO

High blood pressure.....YES NO

Angina.....YES NO

Heart Attack.....YES NO

Coronary artery disease.....YES NO

Tumors/ cancer.....YES NO

Kidney disease.....YES NO

Emphysema.....YES NO

Thyroid condition/goiter.....YES NO

Arthritis/rheumatism.....YES NO

Artificial joints/limbs.....YES NO

Hepatitis.....YES NO

Ulcers.....YES NO

Please describe any disease, condition or problem not listed above that you feel we should know about.

Is there any activity your doctor says you cannot do? If so, explain _____

Primary Physician's Name _____ Phone _____

Former Podiatrist's Name _____ Phone _____

What did she/he treat you for? _____

Have you ever had any serious trouble associated with previous foot treatment? If yes, please explain _____

Date of last visit to your primary physician _____

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have a change in my health or change in my medication, I will inform the physician at the next appointment.

Signature of patient, parent or guardian _____ Date _____