



BABAJIDE OGUNLANA, DPM, PLLC
 West Houston Foot & Ankle Center

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HELLO AND WELCOME TO OUR OFFICE! THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND FOR YOUR HEALTH.

PATIENT INFORMATION -CONFIDENTIAL

Patient's Name _____ Date of Birth _____ Age _____
 Home Address _____ City, State, Zip _____
 Home Phone _____ Cell Phone _____
 Employer _____ Occupation _____
 Work Address _____ Work Phone _____
 Social Security Number _____ Driver's License _____
 Sex Female Male Marital Status **M S D W** Spouse/Parent/Guardian Name _____
 Emergency Contact _____ Phone Number _____

INSURANCE/RESPONSIBLE PARTY INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Policy ID		
Group #		
Policy Holder's First Name		
Policy Holder's Last Name		
Policy Holder's SS#		
Policy Holder's Date of Birth		
Patient's Relationship to Policy Holder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Policy Holder's Gender		
Policy Holder's Address, City, Zip		
Claims Mailing Address		
Phone #		

MEDICAL INFORMATION

Name of Family Physician _____

Present Foot Problem

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Ingrown toe nail | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Other Explain _____ |
| <input type="checkbox"/> Bunion | <input type="checkbox"/> Hammer Toes | <input type="checkbox"/> Diabetic Foot Care | |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Foot/Nail Care | <input type="checkbox"/> Orthotics | |

How is your general health? Good Fair Poor

Are you taking any medications at present? Yes No If yes what? _____

Have you ever experienced any allergic reactions or adverse effects from any of the following?

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Tape | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dyes/Iodine |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Latex-Rubber | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local anaesthetics | <input type="checkbox"/> General Anaesthetics | <input type="checkbox"/> Other antibiotics | <input type="checkbox"/> Other pain medications | <input type="checkbox"/> Non-steroidal medications |

Do you have or have you ever you ever had any of the following: (Check if yes)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Difficulty Healing | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Ankle/Leg Swelling | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Any Heart Troubles | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Leg Ulceration | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Foot Ulcer | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI or Rectal Bleeding | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Night Cramps | <input type="checkbox"/> Weak Ankles |
| <input type="checkbox"/> Blood Problem | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Phlebitis/Calf Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Poor Circulation | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shortness of Breath | _____ |

Please list all previous Injuries _____

Please list all previous Surgeries _____

SOCIAL HISTORY

Do you smoke? Yes No Cigarettes / Pipe / Cigar Amount per day _____ # years _____ Quit Date _____

Do you drink alcohol? Yes No Type _____ Amount per day _____ # years _____ Quit Date _____

Recreational Drugs? Yes No Type _____ Amount per day _____ # years _____ Quit Date _____

How did you hear about our office? (Please give names)

- Friend: _____ Yellow Pages Other: _____
- Doctor: _____ Newspaper: _____
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CONSENTS

- ⇒ I hereby give WEST HOUSTON FOOT & ANKLE CENTER: Dr. Babajide Ogunlana permission to examine and treat my feet. I agree to be responsible for all medical bills.
- ⇒ In consideration of services rendered, I hereby authorize and direct all insurance company(ies) under which I am insured to pay directly to the doctors all benefits due under said policy(ies) by reason of services rendered therein.
- ⇒ Each person signing this consent is financially responsible for charges not collected by this assignment.
- ⇒ All professional services rendered are charged to the patient. It is customary to pay for services rendered unless other arrangements have been made in advance with the office administrator.

Patient/Parent/Guardian's Signature _____ Date _____