

**Northern Utah Podiatry**  
William W. Martin, DPM

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History**

Foot/Ankle Complaints: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle all that apply:

Heart disease	Kidney disease
High Blood Pressure	GERD
Stroke	Stomach ulcers
Liver Disease	Alcohol use
Gout	Tobacco use
Decreased circulation	Asthma
Diabetes	Pregnant
Cancer	Breast feeding
Anemia	Childhood disease
Blood clots	Arthritis

Explanation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries

Operation	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Medications

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

I have had access to the Notice of Privacy Practice (HIPAA) for Northern Utah Podiatry: \_\_\_\_\_(initial)

I authorize Northern Utah Podiatry to share any medical information with my primary care physician: \_\_\_\_\_(initial)

**Personal Information**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_  
SS# \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Emergency Number \_\_\_\_\_

**Financial Information**

Primary insurance \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Policy holder:  
Date of birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone number \_\_\_\_\_

Secondary insurance \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Policy holder:  
Date of birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone number \_\_\_\_\_

**For Our Information**

Referred by: \_\_\_\_\_  
Family member seen: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_

**Consent for Service**

I hereby authorize William W. Martin, DPM to render any medical and surgical treatment as deemed necessary in the diagnosis of lower extremity problems for the above patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_

(continued on back)