



Scott Nelson DPM, P.A.  
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Patient's First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Male or Female Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 \_\_\_\_\_ Ph#: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Date last seen by Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY INFORMATION:**

Employee Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work: \_\_\_\_\_  
 Employed by: \_\_\_\_\_ Employee/Insured Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**IMMUNIZATION RECORD (Record the date/year of the last dose taken if known)**

Tetanus:	FLU Vaccines:
Hepatitis Vaccine:	Pneumonia Vaccine:
Other:	Other:

**ALLERGY – Describe Reaction**


List all Medications including Prescription, Over the Counter, Herbals, etc.

<b>Date Began</b>	<b>Medication Name</b>	<b>Dosage</b>	<b>How Often Taken</b>	<b>Reason for Taking</b>	<b>Prescribing Physician</b>