PATIENT REGISTRATION

Legal Name: _____
First Name MI Last Name

Date of Birth: _____ Social Security #: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner ❑ Separated ❑ Divorced ❑ Widowed

Race: _____ Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Patient Declined

Primary Language: _____

Physical Address: _____
Street Address City State Zip

Financial Information: ❑ Self-Pay ❑ Insurance ❑ Medicare ❑ Worker's Compensation

Primary Insurance Carrier: _____

ID: _____ Group #: _____ Phone #: _____

Secondary Insurance Carrier: _____

ID: _____ Group #: _____ Phone #: _____

Employment: ❑ Employed ❑ Unemployed ❑ Student ❑ Retired/Other

Employer Name (if applicable): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred Method of Correspondence:

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ PT Portal ❑ Email ❑ Postal Service

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Name of person(s) who can have access to your records/PHI or pick up items for you: _____

Primary Care Physician: _____ PCP Office Phone: _____

Referred By: _____

Reason for Claim:

❑ Compensation/Work Related ❑ Automobile ❑ Other Liability ❑ Not Related to Work/Auto/Liability

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Arya Foot & Ankle immediately of any changes to the above information and **annually** upon the office's request.

Patient or Legal Authorized Representative:

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

ARYA FOOT & ANKLE
3104 E. Indian School Road, Ste. 110, Phoenix, AZ 85016 | aryafootandankle.com | Phone: 602.309.8788

REASON FOR YOUR VISIT

Legal Name: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Shoe Size: _____

❑ PCP or ❑ Referring Physician: _____ Date Last Seen: _____

How did you hear about Arya Foot & Ankle? _____

Reason for Visit: _____ Date Occurred: _____

Current Problem

Location (Where – mark on diagram)

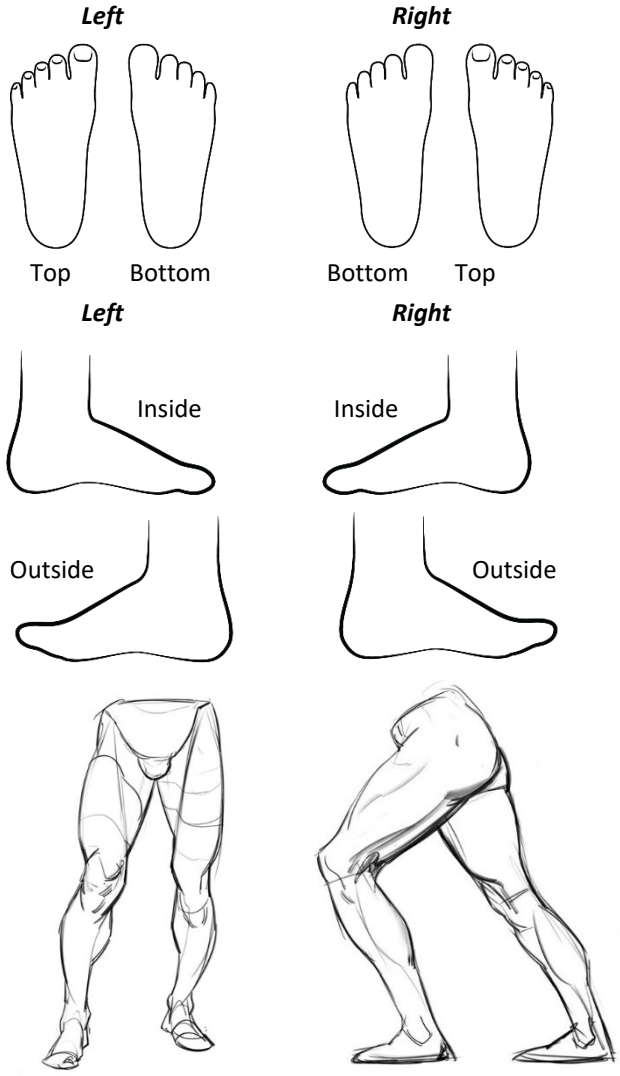
❑ Bottom of ❑ Left ❑ Right
❑ In between ❑ Outside of ❑ Top of
❑ Inside of

Site (What – mark on diagram)

❑ Ankle ❑ Foot/Feet ❑ Toe(s)
❑ Arch ❑ Heel ❑ Toenail
❑ Ball of Foot ❑ Hip ❑ Other: _____
❑ Calf ❑ Leg

Quality

❑ Achy ❑ Inflamed ❑ Tender
❑ Brittle ❑ Itching ❑ Thick
❑ Bruised ❑ Numb ❑ Tight
❑ Burning ❑ Pressure ❑ Tingling
❑ Cramping ❑ Red ❑ Other: _____
❑ Deep ❑ Sharp
❑ Dull ❑ Stabbing
❑ Improving ❑ Swollen



Pain Scale

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑
0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

How long has the problem bothered you? _____

When does it bother you? _____

Cause/Context

❑ Fall ❑ Foot Type ❑ Increased Activity ❑ Injury ❑ Ortho ≥ 1 year
❑ Running ❑ Standing ❑ Unknown ❑ Other: _____

Better with: _____

Worse with: _____

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PAST MEDICAL, SURGICAL, SOCIAL HISTORY

Are you diabetic? ❑ Yes ❑ No If yes, how long? _____ What type? _____

Most recent A1C: _____ Date: _____

Past Medical History

❑ Arthritis	❑ DVT (Blood Clot)	❑ HIV	❑ Osteoporosis
❑ CAD (Coronary Artery)	❑ Dementia	❑ Kidney Disease	❑ RSD/CRPS Reflex
❑ CHF (Heart Failure)	❑ Diabetes	❑ MRSA Infection	❑ Stroke
❑ Cancer	❑ Gout	❑ Neuropathy	❑ Other: _____
			❑ **No Known Problems**

Previous Procedures or Surgeries

❑ Amputation	❑ Hammer Toe Surgery	❑ Neuroma
❑ Angioplasty/stent	❑ Ingrown Toenail	❑ Pacemaker
❑ Bunion	❑ Knee Surgery	❑ Other: _____
❑ Coronary Bypass	❑ Lower Extremity Bypass	❑ **No Surgical History**

Family History

Any known medical conditions in your family?

❑ Father: _____

❑ Mother: _____

❑ Grandparents: _____

Social History

Tobacco	Alcohol	Recreational Drug
❑ **Never Smoked**	❑ **No History of Use**	❑ **No History of Use**
❑ Current Every Day	❑ Heavy (≥ 7 drinks/week)	❑ Currently Use
❑ Current Some Days (Social)	❑ Light (< 7 drinks/week)	❑ Have Used
		❑ Treated for Substance Abuse

Education

❑ Grade School ❑ High School ❑ College ❑ Grad School

Occupation

Employer: _____ Job Title: _____ ❑ Not Employed

Job Requires: ❑ Climbing Stairs ❑ Lifting 10+ lbs ❑ Sitting ❑ Standing ❑ Traveling ❑ Walking

Activities

❑ Aerobics	❑ Bowling	❑ Football	❑ Gymnastics	❑ Swimming	❑ Yoga
❑ Baseball	❑ Cycling	❑ Hiking	❑ Running	❑ Tennis	❑ Other:
❑ Basketball	❑ Dancing	❑ Golf	❑ Soccer	❑ Walking	_____

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REVIEW OF SYMPTOMS AND MEDICATIONS

Other Symptoms – *Mark "None" for each condition that does not apply.*

General

❑ Chills ❑ Weakness ❑ Weight Loss ❑ **None**
❑ Fever ❑ Weight Gain ❑ Other: _____

Eyes	**Ears, Nose, and Throat**	**Respiratory**	**Intestinal**	**Musculoskeletal**
❑ Blurry Vision	❑ Dizziness	❑ Asthma	❑ Abdominal Pain	❑ Artificial Joints
❑ Cataracts	❑ Frequent Sore Throat	❑ Short of Breath	❑ Diarrhea	❑ Gout
❑ Eyeglass Use	❑ Hearing Impairment	❑ Snoring	❑ Nausea	❑ Joint Pain
❑ Vision Loss	❑ Sinus Issues	❑ Wheezing	❑ Vomiting	❑ Muscle Cramps
❑ **None**	❑ **None**	❑ **None**	❑ **None**	❑ **None**

Review of Symptoms – *Mark "None" for each condition that does not apply.*

Heart	**Psychiatric**	**Skin**	**Neurological**
❑ Chest Pain	❑ Anxiety	❑ Non-healing wound	❑ Migraines
❑ High Blood Pressure	❑ Depression	❑ Nail Appearance Change	❑ Numbness
❑ Swelling in Legs	❑ Mood Swings	❑ Wart	❑ Paralysis
❑ **None**	❑ **None**	❑ **None**	❑ **None**

Endocrine	**Hematological**	**Immunological**	**Urinary/Reproductive**
❑ Diabetes	❑ Anemia	❑ Allergies	❑ Blood Urine
❑ Excessive Urination	❑ Bleeding Easily	❑ HIV	❑ Pregnant
❑ Increased Thirst	❑ Blood Transfusions	❑ Recurrent Infections	❑ Urinary Incontinence
❑ Thyroid Trouble	❑ Easy Bruising	❑ Seasonal Allergies	❑ **None**
❑ **None**	❑ **None**	❑ **None**	

Medication History ❑ ***Consent for medication history download from pharmacy (limited to certain plans)***

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____
Street Address City State Zip

Medication Dose Frequency

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies

❑ Ester Anesthetic ❑ Milk ❑ Sulfa ❑ **No Known Allergies**
❑ Latex ❑ Penicillin ❑ Other: _____

Patient or Legal Authorized Representative:

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

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CLEAR FORM