PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME
LAST FIRST M.I. DATE

ADDRESS CITY STATE ZIP

PHONE #'S
HOME WORK CELL

DOB AGE (CIRCLE) M F SSN# MARITAL STATUS

EMAIL ADDRESS:

INCASE OF EMERGENCEY CONTACT PHONE

ADDRESS CITY STATE ZIP

RESPONSIBLE PARTY

NAME (If insurance is through your name please write SELF)
LAST FIRST M.I. DATE

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE SSN#

EMPLOYER ***OCCUPATION***

ADDRESS CITY STATE ZIP

INSURANCE INFO

PRIMARY INSURANCE

COMPANY

INSURED NAME

RELATIONSHIP DOB

COPAY AMT

POLICY # GRP#

SECONDARY INSURANCE

COMPANY PHONE

INSURED NAME

RELATIONSHIP DOB

COPAY AMT

POLICY # GRP#

AUTHORIZAION

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM., TO MY INSURANCE CARRIER, (OR IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION), AND TO ANY CONSULTING PHYSICIAN. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME IN WRITING.

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

PATIENT INFORMATION

(CONFIDENTIAL Information- Important for our files and your good health!)

Family Physician: _____

Former foot/ankle specialist: _____ Phone: _____

What did he/she treat your for? _____

How did you hear of our practice? _____

State in your own words medical reason(s) for coming to our office today:_____

_____ How long has this been a problem?_____

Pharmacy: _____**City**:_____ **Street**_____ **Phone#:**_____

Do you have any **allergies**? NO YES List::_____

Prescription Medications (including dosages) _____

_____

_____

PLEASE INDICATE BY CIRCLING THOSE THAT APPLY TO YOUR MEDICAL HISTORY...

Anemia	YES	NO	Kidney Problems	YES	NO	Thyroid Disease	YES	NO
Arthritis	YES	NO	Liver Problems	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Multiple Sclerosis	YES	NO	Vision Trouble	YES	NO
Cancer	YES	NO	Nervous Condition	YES	NO	Poor Circulation	YES	NO
Diabetes	YES	NO	Pacemaker	YES	NO	Numbness in feet or legs	YES	NO
Epilepsy	YES	NO	Pneumonia	YES	NO	Pain in feet or legs at night	YES	NO
Gout	YES	NO	Rheumatic Fever	YES	NO	Pain in feet or legs as you walk	YES	NO
Heart Problems	YES	NO	Skin Problems	YES	NO	Venereal Disease	YES	NO
High Blood Pressure	YES	NO	Stroke, TIA, Brain Attack	YES	NO	HIV+, AIDS, ARC	YES	NO
High Cholesterol	YES	NO	Stomach Ulcers	YES	NO	Other....	YES	NO

Have you had any surgical operations? NO YES If YES please list:

_____

Family History: Please Circle any past the health of your family members as best you can. Indicate if any have had:

MOTHER: Is she: ALIVE or DECEASED If not deceased how old is she? _____

Arthritis Asthma Cancer Diabetes Foot/Ankle Pain Heart Problems High Cholesterol High Blood Pressure Kidney Disease Stroke/TIA

FATHER: Is he: ALIVE or DECEASED If not deceased how old is he? _____

Arthritis Asthma Cancer Diabetes Foot/Ankle Pain Heart Problems High Cholesterol High Blood Pressure Kidney Disease Stroke/TIA

Do you currently **smoke**? NO YES How much? _____ Have you smoked in the past? NO YES

Drink **alcohol**? NO YES Do you use drugs? (Illegal, narcotics, etc.) NO YES If yes, which ones? _____

Current Height _____ Weight_____ Shoe Size _____

Patient Signature _____ Date _____

ACKNOWLEGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Signature

_____
Parent or Authorized Represntative (if applicable)