Desert
Foot and Ankle, P.C.

1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
480-844-8218 Fax 480-844-9950
www.desertfootandankle.com

PATIENT REGISTRATION

Patient Name_____ Age_____ Birthdate_____
Parent/ Guardian name (if minor)_____
Billing Address_____City_____State_____Zip_____
Permanent Address_____City_____State____ Zip_____
Home Phone_____ Work Phone_____ Cell_____
May we leave a message regarding medical care, billing, or other issues? ( ) Yes ( ) No
Would you like to receive text message appointment reminders? ( ) Yes ( ) No
Email address_____ Race/ Ethnicity (optional)_____
Patient Social Security #_____ Sex: ____Male ____Female
Marital Status: _____Married _____Single _____Other
Primary Care Doctor_____Phone_____
Referred by_____
Full Time Student? Y N Employer name_____
In case of emergency notify_____
Emergency contact phone_____ Relationship to patient_____

Who is responsible for this account?
___Self (skip this section) ___Spouse ___Father ___ Mother ___Other_____
Name_____ Birthdate_____
Social Security Number_____
Home Phone_____ Cell_____Email address_____
Employer_____Work Phone_____
Billing Address_____

INSURANCE INFORMATION

Primary Insurance Company_____
Insurance ID Number_____ Group Number_____
Policy Holder Name_____
Relationship to Patient_____ Birthdate_____

Secondary Insurance Company_____
Insurance ID Number_____ Group Number_____
Policy Holder Name_____
Relationship to Patient_____ Birthdate_____

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1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
16838 E. Palasades Blvd., Suite A105, Fountain Hills, Arizona 85268
480-844-8218 Fax 480-844-9950
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Patient's Name _____ Birthdate _____

Height _____ Weight _____ Shoe Size _____

Chief Complaint (reason for visit) _____

If Injury was it: Auto accident? Y N Work related? Y N Date of Injury _____

Medications: Prescriptions & Non-Prescriptions (include herbal remedies) ☐ I do not take any medications

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN

Pharmacy Name & Zip Code _____

Please check "√" if you currently have or if you have had a history of:

ALLERGIES		SURGERIES	YEAR		AUTOIMMUNE HISTORY	
Adhesives		Appendectomy			Lupus	
Anesthetics		Arthroscopy			Sarcoidosis	
Antihistamines		Back			Scleroderma	
Aspirin		Bladder			Other	
Codeine		Breast L R				
Darvon		Colon			BLOOD DISORDERS	
Demerol		Ears L R			Anemia	
Iodine/Betadine		Eyes L R			Frequent Bruising	
Latex products		Foot L R			Blood Transfusions	
Mercurial		Gall Bladder			Leukemia	
Merthiolate		Heart			Trouble Clotting Blood	
Novocaine		Hernia			Other	
Nylon/Plastic		Hip L R				
Penicillin		Hysterectomy			CIRCULATORY HISTORY	
Seconal		Knee L R			Blood Clots	
Sulfa		Neck			Hodgkin's Disease	
Tetanus		Nose			Legs/Feet Swelling	
Tetracycline		Prostate			Lymphoma	
Other		Shoulder L R			Phlebitis	
		Tonsillectomy			Varicose Veins	
		Other			Vascular Disease	
					Other	
		ANESTHESIA PROBLEMS? Y N				

Past Accidents / Injuries _____

Please check "√" if you currently have or if you have had a history of:

CARDIAC HISTORY		GENITOURINARY		RESPIRATORY	
Angioplasty		Bladder Infections		Asthma	
Atrail Fibrillation		Blood in Urine		Bronchitis	
Chest Pain (Angina)		Dialysis		COPD	
Congestive Heart Failure		Kidney Problems / Stones		Chronic Cough	
Cholesterol Issues		Painful Urination		Emphysema	
Coronary Artery Disease		Prostate Problems		Hay Fever	
Heart Attack		Renal Failure		Pneumonia	
High Blood Pressure		Other		Shortness of Breath	
Irregular Heart Beat				Sleep Apnea	
Mitral Valve / Valve Problems		**INFECTIOUS DISEASE**		Tuberculosis	
Murmur		C-difficile		Valley Fever	
Pacemaker / Defibrillator		Fever Currently		Wheezing	
Cardiac Stents		HIV / AIDS		Other	
Other		Mononucleosis			
ENDOCRINE HISTORY		MRSA		**REPRODUCTIVE**	
Diabetes		Tuberculosis		Are You Pregnant?	
Hypoglycemia		Other		Endometriosis	
Thyroid Problems				Fibroids	
Unexplained Weight Loss		**MUSCULOSKELETAL**		Breast Feeding Currently	
Other		Arthritis Osteo / Rheumatoid		Other	
HEAD		Chronic Back Problems			
Blindness		Difficulty Opening Mouth		**SKIN DISORDERS**	
Cataracts L R		Fibromylagia		Eczema	
Difficulty Swallowing		Gout		Psoriasis	
Deafness L R		Joint Pain		Rash Currently	
Glaucoma L R		Metal, Pins, Plates, Screws		Skin Cancer	
Hard of Hearing L R		Muscle Pain, Weakness		Skin Sores or Open Wound	
Head / Neck Injury		Polio		Trouble Healing Wounds	
Macular Degeneration		Other		Other	
Nose Bleeds					
Other		**NEUROLOGICAL**		**SUBSTANCE USE**	
GASTROINTESTINAL		Alzheimer's / Dementia		Alcohol Present / Past	
Cirrhosis / Liver Disease		Aneurysm		How Much?	
Colitis / Irr. Bowel Disease		Depression		Smoking Present / Past	
Colon Problems / Polyps		Head Injury		How Much?	
Crohn's Disease		Headaches / Migraines		Living with a Smoker?	
Diverticulosis		Memory Loss		Other Substances Used:	
Heartburn (Frequent)		Multiple Sclerosis			
Hemorrhoids		Numbness & Tingling			
Hepatitis		Parkinson's Disease			
Hiatal Hernia		Seizures / Epilepsy		**CANCER OF ANY KIND** (List)	
Pancreatitis		Stroke/TIA or mini-stroke			
Reflux Disease / GERD		Tremors			
Stomach Problems / Ulcers		Other			
Other					

Patient's Name _____ Date _____

Desert Foot & Ankle PC

Family Medical History Questionnaire

Date:	
Patient Name	
Date of Birth:	

Has your mother (M), father (F), sister (S), or brother (B) had:

Asthma/Wheezing	Yes ____	No ____	Who? ____
TB/Lung Disease	Yes ____	No ____	Who? ____
Cystic Fibrosis	Yes ____	No ____	Who? ____
HIV/AIDS	Yes ____	No ____	Who? ____
Heart Disease (Cardiovascular Disease)	Yes ____	No ____	Who? ____
Sudden Cardiac Death	Yes ____	No ____	Who? ____
High Blood Pressure (Hypertension)	Yes ____	No ____	Who? ____
Stroke	Yes ____	No ____	Who? ____
High Cholesterol	Yes ____	No ____	Who? ____
Blood Disorders	Yes ____	No ____	Who? ____
Sickle Cell	Yes ____	No ____	Who? ____
Anemia	Yes ____	No ____	Who? ____
Thalassemia	Yes ____	No ____	Who? ____
Clotting Disorders	Yes ____	No ____	Who? ____
Diabetes Type I	Yes ____	No ____	Who? ____
Diabetes Type 2	Yes ____	No ____	Who? ____
Seizures	Yes ____	No ____	Who? ____
Cancer	Yes ____	No ____	Who? ____
Breast	Yes ____	No ____	Who? ____
Cervical	Yes ____	No ____	Who? ____
Colorectal	Yes ____	No ____	Who? ____
Other_____	Yes ____	No ____	Who? ____
Birth Defects	Yes ____	No ____	Who? ____
Hearing Loss	Yes ____	No ____	Who? ____
Speech Problems	Yes ____	No ____	Who? ____
Kidney Disease	Yes ____	No ____	Who? ____
Alcohol/ Drug Abuse	Yes ____	No ____	Who? ____
Hepatitis/ Liver Disease	Yes ____	No ____	Who? ____
Thyroid Disease	Yes ____	No ____	Who? ____

Has any family member ever had an unexplained, unexpected death before age 50?

Yes ____ No _____ Who? _____

If yes, please describe: _____

_____