YOUR *next* STEP
The Foot and Ankle Care Center

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PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY **Date:** _____ **MRN:** _____

PATIENT INFORMATION			
Patient's Last Name: First: Middle Initial:		Date of Birth:	Sex: ☐ Male ☐ Female
Patient's Address: Street Info			Apt. #:
City:	State, ZIP:	Patient's Home Phone #:	Patient's Cell Phone #:
Billing Street Address of Responsible Party - If Different from above:		Race (Optional): ☐Black or African American ☐Caucasian ☐Hispanic ☐Other Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other	
City:	State, ZIP:	Social Security #:	Email:
Employer's Name		Work Phone #:	
What is your occupation?			
Pharmacy Name: Address & Telephone #:			
Referring Physician's Name & Telephone #:		Primary Care Physician's Name & Telephone #: (if different than referring)	

INSURANCE INFORMATION		
Primary Insurance Company Name:		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Policyholder's Date of Birth:	Policyholder's Sex ☐ Male ☐ Female	Effective Dates of Insurance:
Secondary Insurance Company Name:		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Policyholder's Date of Birth:	Policyholder's Sex ☐ Male ☐ Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Home Phone #:	Work Phone #:	Cell Phone #:

PLEASE HAND THIS FORM AND YOUR INSURANCE CARD(S) TO THE RECEPTIONIST.

MEDICAL HISTORY

Name _____ Age _____ Date of Birth _____
Reason for today's visit _____
Are you seeing the doctor because of an accident? Yes No
Is this a Workers' Compensation case? Yes No
Who referred you to this office? _____
Who is your primary care physician? _____
Are you allergic to any medications? Yes No If yes, list _____
List all medications you are taking; include non-prescription and over-the-counter:
_____
_____
Are you taking aspirin, Advil, ibuprofen or other pain relievers? Yes No
Do you have, or have you ever had diseases or conditions of the following? Please check all that apply:

Lungs	Other Systemic	DETAILS
Emphysema	Allergies	_____
Asthma	Diabetes	_____
	Thyroid	_____
Vascular	Kidney	_____
Artificial Heart Valve	Bladder	_____
High Blood Pressure	Stomach	_____
Chest Pain	Bowel	_____
Heart Attack	Hepatitis/Yellow	_____
Heart Murmur	Glaucoma	_____
Irregular Heartbeat	Arthritis	_____
Pacemaker	Seizures	_____
Phlebitis	Cancer	_____
Elevated Cholesterol	Anemia	_____
	Gout	_____

***Medicare patients: Please be advised that certain vascular criteria must be met in order for foot care to be a covered service.**

Do you now experience or have you ever experienced cramping in the feet or legs at night or while walking? Yes No
Do you now or have you ever had cold feet or legs? Yes No
Do you now or have you ever had swelling in your feet or legs? Yes No
Do you now or have you ever had abnormal sensations in your feet or legs? Yes No
Do you now or have you ever had burning in your feet or legs? Yes No

Do you drink Alcohol? Yes No How much? _____
Do you use or have you ever-used IV drugs? Yes No (what? _____)
Have you ever had or been exposed to HIV/AIDS? Yes No
Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? _____

Skin
Have you ever had skin cancers? Yes No If yes, what kind? _____
Has anyone in your family ever had melanoma? Yes No If yes, who? _____
Do you have a history of any skin diseases? Yes No If yes, please list: _____
_____

List any other disease or condition we should know about: _____
List any surgical procedures: _____
_____
Do you smoke? Yes No
Women: are you pregnant? Yes No Not sure Planning
Women: are your menstrual periods regular? Yes No
Do you have artificial joints? Yes No

Reviewed by Physician: _____ Date: _____