YOUR *next* STEP
The Foot and Ankle Care Center

39 Rittenhouse Pl
Ardmore, PA 19003
Phone: (610) 642-8837

1410 Russell Rd, Suite 201
Paoli, PA 19301
Phone: (610) 644-6501

797 E. Lancaster Ave., #9
Downingtown, PA 19335
Phone: (610) 873-0322

1324 MacDade Blvd.
Woodlyn, PA 19094
Phone: (484) 480-4509

Eric Ricefield, D.P.M. **Mark Yagodich, D.P.M.** **Aliza Eisen, D.P.M.**

PATIENT REGISTRATION FORM

DATE: **MRN:**

PATIENT INFORMATION — PLEASE PRINT CLEARLY

Patient's Last Name: First: Middle Initial: | Date of Birth: | Sex: ☐ Male ☐ Female

Social Security #: Email:

Patient's Home Phone #: Patient's Cell Phone #:

Race (Optional): ☐Black or African American ☐Caucasian ☐Hispanic ☐Other
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Patient Home Address:
Address: _____
Apt. #: _____
City: _____
State, ZIP: _____

Billing Street Address of Responsible Party - If different from Patient Home
Address: _____
Apt. #: _____
City: _____
State, ZIP: _____

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT

Name:
Best Contact Number:
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Dependent ☐ Other
Email:

Employer's Name | Work Phone #:

What is your occupation?

Pharmacy Name: Address & Telephone #:

Who referred you to this office?
Referring Physician's Name & Telephone #:
Primary Care Physician's Name & Telephone #: (if different than referring)

INSURANCE INFORMATION

Primary Insurance Company Name:
ID or Policy Number: _____
Group Number: _____
Insurance Company Phone #: _____
Effective Dates of Insurance: _____
Name of Policyholder: _____
Patient's Relationship to Policyholder:
☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other
Policyholder's Date of Birth: _____
Policyholder's Sex: ☐ Male ☐ Female

Secondary Insurance Company Name:
ID or Policy Number: _____
Group Number: _____
Insurance Company Phone #: _____
Effective Dates of Insurance: _____
Name of Policyholder: _____
Patient's Relationship to Policyholder:
☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other
Policyholder's Date of Birth: _____
Policyholder's Sex: ☐ Male ☐ Female

How are you feeling today? Review of Systems (Please check boxes that apply)

☐ weight loss
☐ weight gain
☐ fatigue
☐ general weakness
☐ fever
☐ visual changes
☐ eye pain
☐ double vision
☐ blurry vision
☐ flashing lights
☐ runny nose
☐ stuffy nose
☐ stuffy ears
☐ ear pain
☐ ringing in ears
☐ chest pain
☐ palpitations
☐ dizziness
☐ faintness
☐ allergic reactions
☐ cough
☐ wheeze
☐ shortness of breath
☐ abdominal pain
☐ difficulty swallowing
☐ nausea
☐ vomiting
☐ heartburn
☐ diarrhea
☐ constipation
☐ falls
☐ muscle pain
☐ stiffness
☐ joint swelling
☐ joint pain
☐ back pain
☐ itching
☐ rashes
☐ excessive dryness
☐ limb weakness
☐ fainting
☐ headache
☐ pins and needles
☐ numbness
☐ poor balance
☐ speech problems
☐ tremor
☐ easy bruising
☐ swelling of lymph nodes
☐ Lightheadedness up on standing
☐ recurrent infections

Name _____ Age _____ Date of Birth _____

Reason for today's visit _____

SOCIAL HISTORY

Do you drink Alcohol? ☐ Yes ☐ No How much? _____

Do you smoke? ☐ Yes ☐ No How much? _____

Do you use or have you ever-used IV drugs? ☐ Yes ☐ No (what?)

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any bad reaction?_____

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

MEDICATIONS/ALLERGIES/SURGERIES

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

Are you allergic to any medications? ☐ Yes ☐ No If yes, list them _____

List any surgical procedures: _____

Do you have artificial joints? ☐ Yes ☐ No If yes, list them_____

MEDICAL HISTORY/CURRENT PROBLEMS/DISEASES OR CONDITIONS (CHECK ALL THAT APPLY)

You	Family Member	
___	___	Asthma
___	___	Arthritis
___	___	Gout
___	___	Eye Injury
___	___	Pneumonia
___	___	Back Problems
___	___	Elevated Cholesterol
___	___	TB
___	___	Fracture
___	___	Dry Eyes
___	___	COPD
___	___	Aneurysm
___	___	Bleeding Problems
___	___	Constant Tearing
___	___	Bronchitis
___	___	Hemophilia
___	___	Eye Infection
___	___	Emphysema
___	___	History Blood Transfusion
___	___	Thyroid
___	___	Eye Disease

You	Family Member	
___	___	Sleep Apnea
___	___	Do you use a CPAP Machine?
___	___	Anemia
___	___	Loss of Vision
___	___	Blood Clots
___	___	Macular Degeneration
___	___	Gallbladder Problems
___	___	Diabetes
___	___	Hyperthyroidism
___	___	Blood sugar under good control?
___	___	Blood sugar poorly controlled?
___	___	Amblyopia
___	___	Spastic Colon
___	___	Blindness
___	___	Diverticulosis
___	___	Grave's Disease
___	___	Glaucoma

You	Family Member	
___	___	Ulcers
___	___	Hypothyroidism
___	___	Cataract
___	___	Cirrhosis
___	___	Migraines
___	___	Aphakia with IOL
___	___	Hepatitis B
___	___	Memory Loss
___	___	High Blood Pressure
___	___	Liver Disease
___	___	Iritis, Uveitis
___	___	Neuromuscular Disease
___	___	Hepatitis C
___	___	Stroke or Paralysis
___	___	Diabetic Retinopathy
___	___	Pancreatitis
___	___	Seizures
___	___	Melanoma
___	___	Retinal Disease
___	___	Hernia
___	___	Depression

You	Family Member	
___	___	Retinal Detachment
___	___	Kidney/Bladder Infection
___	___	Mitro-Valve Prolapse
___	___	Anxiety
___	___	Strabismus
___	___	Blood in Urine
___	___	Rosacea
___	___	Post-Menopausal
___	___	Diplopia
___	___	Kidney Disease
___	___	Breast CA
___	___	Skin CA
___	___	Chalazion
___	___	Kidney Stones
___	___	Keloid
___	___	Loss of Hearing
___	___	Skin Disease
___	___	Renal Failure
___	___	Cancer
___	___	Tinnitus
___	___	Dialysis

You	Family Member	
___	___	Motion Sickness or P/O Nausea
___	___	Nose Bleed
___	___	BPH
___	___	Cold Sores
___	___	Sinus Problems
___	___	Prostate CA
___	___	Heart Murmur
___	___	HIV
___	___	Heart Attack
___	___	Latex allergy
___	___	Heart Failure
___	___	Nursing
___	___	Pacemaker/ Defibrillator
___	___	Other, not Listed

_____

_____

_____

_____

Reviewed by Physician: _____ Date: _____