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

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

Employer's Name | Work Phone #:

What is your occupation?

Pharmacy Name: Address & Telephone #:

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

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	You	Family Member	You	Family Member	You	Family Member	You	Family Member
___	___ Asthma	___	___ Sleep Apnea	___	___ Ulcers	___	___ Retinal Detachment	___	___ Motion Sickness or P/O Nausea
___	___ Arthritis	___	___ Do you use a CPAP Machine?	___	___ Hypothyroidism	___	___ Kidney/Bladder Infection	___	___ Nose Bleed
___	___ Gout	___	___ Anemia	___	___ Cataract	___	___ Mitro-Valve Prolapse	___	___ BPH
___	___ Eye Injury	___	___ Loss of Vision	___	___ Cirrhosis	___	___ Anxiety	___	___ Cold Sores
___	___ Pneumonia	___	___ Blood Clots	___	___ Migraines	___	___ Strabismus	___	___ Sinus Problems
___	___ Back Problems	___	___ Macular Degeneration	___	___ Aphakia with IOL	___	___ Blood in Urine	___	___ Prostate CA
___	___ Elevated Cholesterol	___	___ Gallbladder Problems	___	___ Hepatitis B	___	___ Rosacea	___	___ Heart Murmur
___	___ TB	___	___ Diabetes	___	___ Memory Loss	___	___ Post-Menopausal	___	___ HIV
___	___ Fracture	___	___ Hyperthyroidism	___	___ High Blood Pressure	___	___ Diplopia	___	___ Heart Attack
___	___ Dry Eyes	___	___ Blood sugar under good control?	___	___ Liver Disease	___	___ Kidney Disease	___	___ Latex allergy
___	___ COPD	___	___ Blood sugar poorly controlled?	___	___ Iritis, Uveitis	___	___ Breast CA	___	___ Heart Failure
___	___ Aneurysm	___	___ Amblyopia	___	___ Neuromuscular Disease	___	___ Skin CA	___	___ Nursing
___	___ Bleeding Problems	___	___ Spastic Colon	___	___ Hepatitis C	___	___ Chalazion	___	___ Pacemaker/ Defibrillator
___	___ Constant Tearing	___	___ Blindness	___	___ Stroke or Paralysis	___	___ Kidney Stones	___	___ Other, not Listed
___	___ Bronchitis	___	___ Diverticulosis	___	___ Diabetic Retinopathy	___	___ Keloid	___	_____
___	___ Hemophilia	___	___ Grave's Disease	___	___ Pancreatitis	___	___ Loss of Hearing	___	_____
___	___ Eye Infection	___	___ Glaucoma	___	___ Seizures	___	___ Skin Disease	___	_____
___	___ Emphysema			___	___ Melanoma	___	___ Renal Failure	___	_____
___	___ History Blood Transfusion			___	___ Retinal Disease	___	___ Cancer		
___	___ Thyroid			___	___ Hernia	___	___ Tinnitus		
___	___ Eye Disease			___	___ Depression	___	___ Dialysis		

Reviewed by Physician: _____ Date: _____