PATIENT REGISTRATION

(Please Print)

Page 1

Date_____/_____/_____

PATIENT INFORMATION:

Patient Name_____ Sex: M____F____
First Last Middle

Home Address_____Apt#_____

City_____ St_____ Zip_____ Home Phone(____)_____-_____

Single___ Married ___ Widowed ___ Separated ___ Divorced __ Cell Phone (____)_____-_____

Date of birth_____/_____/_____ Age_____ Height _____ Weight _____  Size _____

Employer _____ Social Security # _____

Occupation _____ Work Phone (_____)_____-_____

In case of Emergency Contact _____Phone (____)_____-_____

Whom may we thank for referring you to this office _____

INSURANCE #1

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

INSURANCE #2

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medial or government benefits to the undersigned Physician or Supplier for services.

Signature _____ Date_____/_____/_____

PATIENT REGISTRATION
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PATIENT'S HEALTH HISTORY:

Foot Symptoms _____

_____

_____ When did symptoms begin _____

Family Doctor _____ Last Visit _____

Podiatrist _____ Last Visit _____

Check any illness or condition you have had:

DIABETES_____ STROKE _____ EPILEPSY_____ HEART DISEASE _____ ASTHMA _____

RHEUMATIC FEVER_____ CANCER_____ HIGH BLOOD PRESSURE_____ AIDS_____

ARTIFICIAL JOINT OR IMPLANT____ CLAUSTROPHOBIA _____ METAL IN BODY _____

STOMACH PROBLEMS____ (G. I. Problems, Ulcers)

Other Medical Conditions Not Listed Above:_____

_____

_____

Are you Pregnant Y____ N____ If you have recently given birth are you nursing? Y____ N ____

Do you need an antibiotic before surgery Y____N____

PREVIOUS SURGERIES _____

_____

_____

MEDICATIONS AND VITAMINS TAKING: _____

_____

_____

Are you **allergic** to any medications No____ Yes____ Please list_____

_____

_____

Do you use **tobacco** products No ___Yes___ DAILY Amount _____

Do you drink **alcoholic** beverages No ___Yes___ DAILY Amount_____

I certify that the above information is correct and best of my knowledge.

Signature_____ Date_____/_____/_____