PATIENT REGISTRATION
(Please Print)

Date_____

PATIENT INFORMATION: Home Phone (_____)_____

Patient Name_____ Sex: M___F___

Home Address_____ City _____ St. _____ Zip _____

Single__Married__Widowed__Separated__Divorced__ Date of birth_____ Age___Height____Weight____

Employer _____Social Security # _____

Occupation _____ Work Phone_____

In case of Emergency Contact _____ Phone_____

Whom may we thank for referring you to this office _____

INSURANCE #1

Name _____Date of birth _____Social Security # _____

Employer_____ Insurance Company _____

INSURANCE #2

Name _____Date of birth _____Social Security # _____

Employer_____ Insurance Company _____

PATIENT'S HEALTH HISTORY:

MY FOOT PROBLEM IS_____

_____

Family Doctor _____Last Visit_____

Podiatrist _____Last Visit_____

Check any illness or condition you have had:

DIABETES_____ STROKE _____ EPILEPSY_____ HEART DISEASE _____RHEUMATIC FEVER_____

CANCER _____ ASTHMA_____HIGH BLOOD PRESSURE_____ARTIFICAIAL JOINT IMPLANT _____

OTHER _____

Pregnant Y____ N____ Do you need an antibiotic before surgery Y____N____

PREVIOUS SURGERIES_____

MEDICATIONS CURRENTLY USING:_____

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_____

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_____