PODIATRIC REGISTRATION AND HISTORY

PATIENT INFO:

Name: _____ SS #_____

Address:_____ City: _____ ST: ____ Zip: _____

Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

Preferred Method of Contact: Home___ Work___ Cell ___ E-mail___

E-mail: _____ Female / Male Birth Date: _____

Age: ____ Married__ Widowed__ Single__ Divorced__ Separated__ Partnered__ Minor__

Primary Language: _____ Race/Ethnicity: _____ Referred By:_____

Primary Care/Physician:_____ Phone:_____ Last Visit: _____

Occupation: _____ Employer: _____

Employer address: _____ Phone: _____

Who is responsible for this account: _____ Relationship:_____

INSURANCE INFO:

Primary Insurance Co:_____ ID:_____

Policy Holder's Name:_____ Birth Date:_____

Relationship to Patient:_____

Secondary Insurance Co:_____ ID:_____

Policy Holder's Name:_____ Birth Date:_____

Relationship to Patient:_____

I certify that I have insurance coverage stated above and assign directly to Dr._____ all Insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X_____ Date:_____ Relationship:_____

HISTORY - PAST / FAMILY / SOCIAL

SELF Past Medical History:

___Arthritis
___Asthma
___Blood Clots
___Circulation
___Depression
___Diabetes
___Excessive Bleeding
___Thyroid Disease
___HIV/AIDs
___High Blood Pressure
___Joint Replacement
___Kidney Disease
___ Anemia
___ Angina
___ Back Problems
___ Cancer
___ Epilepsy
___ COPD
___ Heart Disease
___ Gout
___ Neuropathy
___ Hepatitis/Liver
___ Phlebitis
___ Psychiatric Care
Other Conditions:_____
_____
_____

PAST Podiatric History

___Athlete's Foot
___Ankle Pain
___Bunion
___Corns or Calluses
___Cramps in Legs
___Flat Feet
___Heel Pain
___Ingrown Toenail
___Numbness in Feet
___Plantar Warts
___Swelling
___Tired Feet
Other Conditions:_____
_____
_____

Family History/Relationship

___ Alcoholism_____
___ Arthritis_____
___ Asthma_____
___ Breast Cancer_____
___Cancer_____
___Diabetes_____
___Heart Disease_____
___Hypertension_____
___High Cholesterol_____
___ Kidney Disease_____
___Smoking_____
___Stroke_____
Other Family Conditions:
_____
_____

Social History:

Drugs:_____
Alcohol:_____
Hobbies:_____
Exercise:_____
Other:_____

Tobacco Use: _____ (Type) _____ (Years smoked)

___Current every day smoker
___Current some day smoker
___Smoker How many years?_____
___Former Smoker Date quit?_____
___Never Smoked

Are you Diabetic?: Y N For how long?_____ Insulin dependent? Y N

SURGICAL HISTORY:

Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____

CURRENT MEDICATIONS:

Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____

ALLERGIES:

___NONE
___Acetaminophen
___Ampicillin
___ASA
___Beta Blockers
___Cefaclor
___Cephalexin
___Ciprofloxacin
___Codeine
___Darvon-N
___Erythromycin
___Ibuprofen
___Morphine
___Narcotics
___Penicillin
___Sulfonamides
___Tetracycline
___Xalatan
___Bees
___Cats
___Dairy Products
___Dogs
___Mites
___Mold
___Pollen
___Thimerisol
___Yeast
Other:_____