

# PODIATRIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? Yes \_\_\_ No \_\_\_

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship \_\_\_\_\_ Date \_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

## 3 CONTACT INFORMATION

Email \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Mobile \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 4 PODIATRIC HISTORY

What is the chief complaint for which you to be treated (Include foot, ankle, knee hip, thigh complaints)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been to a Foot Doctor before? \_\_\_ Yes \_\_\_ No

Name \_\_\_\_\_  
Last Visit \_\_\_\_\_

Is there any personal or family history of diabetes? \_\_\_ Yes \_\_\_ No

Your Occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_

Years Smoked \_\_\_\_\_

Athletic activities in which you participate (please list and indicate frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

Ankle Pain \_\_\_ Athlete's Foot \_\_\_

Bunions \_\_\_ Corns & Callouses \_\_\_

Cramps or Numbness in Feet or Legs \_\_\_

Flat Feet \_\_\_ Foot or Leg Cramps \_\_\_

Heel Pain \_\_\_ Ingrown Toenails \_\_\_

Plantar's Warts \_\_\_ Tired Feet \_\_\_

Swelling in Ankles or Feet \_\_\_

## 5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	___	___	Diabetes	___	___	Psychiatric Care	___	___
Allergies to Anesthetics	___	___	Ear Problems	___	___	Radiation Treatment	___	___
Allergies to Medicine or Drugs	___	___	Epilepsy	___	___	Rash	___	___
Anemia	___	___	Eye Problems	___	___	Respiratory Disease	___	___
Angina	___	___	Fainting	___	___	Rheumatic Fever	___	___
Arthritis	___	___	Foot or Leg Cramps	___	___	Shortness of Breath	___	___
Artificial Heart Valves or Joints	___	___	Gout	___	___	Sinus Problems	___	___
Asthma	___	___	Headaches	___	___	Special Diet	___	___
Back Problems	___	___	Heart Disease	___	___	Stroke	___	___
Bleeding Disorders	___	___	Hemophilia	___	___	Swelling in Ankles, Feet	___	___
Cancer	___	___	Hepatitis or Jaundice	___	___	Swollen Neck Glands	___	___
Chemical Dependency	___	___	High Blood Pressure	___	___	Tired Feet	___	___
Chest Pain	___	___	Kidney Problems	___	___	Tuberculosis	___	___
Chronic Diarrhea	___	___	Liver Disease	___	___	Ulcers	___	___
Circulatory Problems	___	___	Low Blood Pressure	___	___	Varicose Veins	___	___
			Nervous Problems	___	___	Venereal Disease	___	___
			Phlebitis	___	___	Weight Loss, unexplained	___	___

Surgeries you have \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_  
 \_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives? \_\_\_\_\_ Yes \_\_\_\_\_ No

## 7 ALLERGIES

___ Adhesive/Tape	___ Local
___ Anticoagulant	___ Novocaine
Therapy	___ Penicillin
___ Aspirin	___ Seafoods
___ Codeine	___ Sulfa
___ Demerol	
___ Iodine	
Other _____	

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_