



PODIATRY AFFILIATES, PC

<http://www.podiatryaffiliates.com>

REGISTRATION FORM (Please Print)

Today's Date / / Office Doctor

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss.	<input type="checkbox"/> Sr. <input type="checkbox"/> Jr.
Street Address	City	State	Zip Code		
Home Phone # ()	Work Phone # ()	Cell Phone # ()	E-Mail Address		
Birth Date / /	Age	Social Security Number	Marital Status Single / Mar	Sex <input type="checkbox"/> M <input type="checkbox"/> F	

INSURANCE INFORMATION

Occupation	Insured Employer	Employer Address
Please Indicate Primary Insurance		Please Indicate Secondary Insurance
Pharmacy Name & Address	Pharmacy Phone Number	Insured's Date of Birth
Insured's Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

Referred to Office by (check all that apply)

- Doctor _____
- Hospital _____
- Insurance Plan _____
- Family _____
- Friend _____
- Internet _____

Person To Notify In Case of Emergency:

Name: _____
 Address: _____
 Telephone Number: _____
 Cell Phone Number: _____

Privacy Information:

May we leave appointment message:

- On answering machine? Y N
- On work voice mail? Y N
- With another person? Y N
- Through the mail? Y N
- On your e-mail? Y N
- On your cell phone? Y N

May we leave medical information:

- On answering machine? Y N
- On work voice mail? Y N
- With another person? Y N
- Through the mail? Y N
- Through e-mail? Y N
- On your cell phone? Y N

MEDICAL HISTORY

PATIENT NAME _____

BIRTH DATE ____/____/____

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Anti-Inflammatory Medication
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tape	<input type="checkbox"/> Nausea From Anesthetic	<input type="checkbox"/> Iodine on Skin
<input type="checkbox"/> Other	<input type="checkbox"/> None		

**MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING:
PRESCRIPTION AND OVER-THE COUNTER)**

Use Other Side Of Page If Necessary

MEDICATION	DOSE	MEDICATION	DOSE

CHIEF COMPLAINT? _____ **HOW LONG?** _____ **MONTHS** _____ **YEARS** _____

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

Surgery Orthotics Oral Medications Cortisone Shots

WHAT OTHER SURGERIES HAVE YOU HAD? _____ **DATE** _____

FAMILY PHYSICIAN INFORMATION

Doctor's Name	Date of Last Visit	Phone Number (____) _____		
Street Address		City	State	Zip Code

SHOE SIZE _____ **HEIGHT** _____ **WEIGHT** _____

DO YOU DRINK? NO YES **DRINKS PER WEEK** _____

DO YOU SMOKE? NO YES **PACK(S) PER DAY** _____

Indicate which of the following you had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Communicable Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Motion Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart (Surgery, Disease, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse/Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Problems / Reflux / Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is there a chance you may be pregnant? Yes No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the office of any change in my health or medication.

X _____ **Date** _____

Patient/Guardian Signature _____ **Date** _____

HISTORY REVIEWED BY: DR. SIGNATURE _____ DATE _____