PATIENT REGISTRATION FORM
PATIENT DATA

NAME_____ SS#_____

Street Address_____ Date of Birth_____

City_____ State_____ Zip Code_____

Home Telephone No:_____ Office No._____ Cell No_____

Sex	Age	Marital Status	Shoe Size	Weight	Height
_____	_____	_____	_____	_____	_____

Spouses Name_____ Spouse's Employer_____

Emergency Contact_____ Phone No._____ Relationship_____

PATIENT EMPLOYER INFORMATION

Employer Name_____ Phone No_____

Employer Address_____ City_____ State_____ Zip_____

INSURED PERSON (IF NOT PATIENT)

Name_____ Phone No._____

Street Address_____ City_____ State_____ Zip_____

Relationship to patient_____ Date of Birth_____ SS#_____

PRIMARY CARE PHYSICIAN_____ Phone # _____

INSURANCE (PLEASE CIRCLE ONE)

Medicare Blue Shield Commercial Workman's Comp Auto HMO Self Pay Med Assistance

ID#_____ Group #_____ Subscriber_____

Secondary Insurance Co Name_____

ID#_____ Group#_____ Subscriber_____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date_____ Signature_____

I hereby authorize payment from my medical insurance carrier to be made on my behalf to Delaware County Foot and Ankle and Ankle Center, P.C. for services furnished to me by said group. I authorize Delaware County Foot and Ankle Center, P.C. to release to my insurance company any medical information needed to determine benefits or benefits payable to related services.

I understand that if, under Medicare or other insurance company program guidelines, a necessary service is determined to be non-covered, and I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the third party payor.

Date:_____ Signature_____

OVER PAGE #2

GENERAL MEDICAL INFORMATION

Describe the current foot problem/reason for today's visit.

_____

_____

_____

HAVE YOU BEEN TREATED FOR:

Ankle Injury ___ Arch Pain _____ Heel Pain _____
Flat Feet _____ Warts _____ Dermatitis _____
Knee Pain _____ Bunions _____ Hammertoes _____
Broken foot bone (s) _____ Corns/callouses _____
Leg or Foot Ulcers _____ Ingrown Nails _____
Childhood Foot Problems _____ Neuropathy _____
Athlete's Foot _____ None of the above _____

Do you have any difficulty in walking _____ YES ___ NO
Do you get leg cramps _____ YES _____ NO
Any pain in calves or buttocks when walking _____
Is the pain relieved by rest _____ YES _____ NO
Are you slow to heal after cuts _____ YES _____ NO

FAMILY HISTORY

List relationship to you of family members who had:

High Blood Pressure _____ Diabetes _____

Cancer _____ Heart problems/Attack _____

Osteoarthritis _____ Rheumatoid Arthritis _____

Are you taking Insulin Yes _____ No _____

Are you taking Coumadin or Plavix Yes ____ No ____

Are you on home oxygen Yes _____ No _____

PLEASE LIST ALL MEDICATIONS BELOW:

_____

_____

_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following: (check all that apply)

Diabetes _____
Chest pain/tightening ____
Kidney Disease _____
Anxiety/Dizzy spells _____
Shortness of Breath _____
Heart attack _____
Headaches _____
Memory Loss _____
Seasonal Allergies _____
Arthritis _____
Vascular Disease _____
GERD/Heartburn _____
Thyroid Disease _____
Spinal Stenosis _____
Other _____

Asthma _____
Cancer _____
Hypertension _____
Stroke/TIA _____
Ulcers _____
TB/Lung Disorder _____
Anemia _____
Depression _____
Gout _____
Osteoporosis _____
Lyme Disease _____
COPD/Emphysema ____
Sciatica _____
Blood Clot/PE _____

ANY FORM of HEPATITIS _____
HIV+ or AIDS _____

Do you have any joint implants _____
Do you have replacement heart valves _____
Do you have any vascular stents _____
Have you had any other serious illness or been Hospitalized, if yes please list below

_____

_____

Please List ALL Surgical Procedures Elective, Emergent & Cosmetic

_____

_____

_____

Do you smoke _____ YES _____ NO Years _____

Did you ever smoke ____ YES ____ NO Years ____

Do you consume alcohol _____ YES _____ NO

If yes, _____ drinks per (Please Circle) Day Week Mon

Do you currently use, or have had a history of abuse of any of the following drugs:

Marijuana _____ Cocaine _____

IV Drugs _____ Opiates _____

Prescription Drugs _____ Other _____

ALLERGIES; IS THERE A HISTORY OF SKIN REACTION OR OTHER OUTWARD REACTION OR SICKNESS FOLLOWING AN INJECTION, ORAL OR TOPICAL ADMINISTRATION OF:

Penicillin _____ Codeine _____

Other Antibiotics _____ Latex _____

Morphine _____ Novocaine _____

Aspirin _____ Adhesive Tape _____

Sulfa Drugs _____ Cortisone _____

Demerol _____ IV Contrast Dye _____

Chemical Allergy _____ Food Allergy _____

Other _____