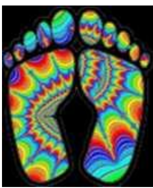

PATIENT REGISTRATION

North Shore Foot & Ankle

Please Print **Date**________________________

PATIENT INFORMATION

Patient Name____ Age_______ Date of Birth________________
(Last) (First) (MI)

Address____

City____ State_________ Zip______________

Home Phone____________________________ Work Phone__________________________ Other__________________________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____________________________ Employer____________________________ Employer's Phone_______________

Spouse's Name___________________________ Date of Birth___________________________

Employer_________________________________ Work Phone _____________________

Whom may we thank for referring you? ____

Family Physician_________________________ Phone Number________________________ Date of Last Visit________________

IN CASE OF EMERGENCY, CONTACT: Name________________________________ Relationship___________________

Home Number___________________________ Work Number___________________________ Ext____________________________

INSURANCE INFORMATION

WE SUBMIT INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. THE PATIENT HOWEVER IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT AND RELEASE

I hereby authorize payment of Medicare or OTHER insurance benefits be made to my physician or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or other insurance carrier any and all information needed to determine these benefits or the benefits payable for related services. I understand and I agree that I am ultimately financially responsible (regardless of insurance status) for the balance on my account for any professional services rendered. I authorize the use of this signature on all insurance submissions.

Signature____

PODIATRIC HISTORY

What is your chief foot complaint?____ Date problem began________________

Have you ever seen a Podiatrist before? ☐ Yes ☐ No Please List: Name & Date________________________________

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

Cigarette/Tobacco use______________________________ Years smoked________________ How much a day________________

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

Height____________________ Weight_______________________ Shoe Size_____________________

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

Ankle Pain	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No	Ingrown Toenails	☐ Yes ☐ No
Athlete's Foot	☐ Yes ☐ No	Foot or Leg Numbness	☐ Yes ☐ No	Plantar Warts	☐ Yes ☐ No
Bunions	☐ Yes ☐ No	Flat Feet	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No
Corn and Calluses	☐ Yes ☐ No	Heel Pain	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No

- OVER -

MEDICAL HISTORY

Place a Mark on “Yes” or “No” to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Diabetes-Type_________	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Angina / Chest Pain	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Artificial Heart Valves			Gout	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
or joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma/			Hemophilia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	High /Low Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Surgeries you have had____

____

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____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins____

____

Pharmacy Name_______________________________________ Pharmacy Location_________________________

Do you take oral contraceptives? ☐ Yes ☐ No   If female are you now, could be or are you trying to get pregnant? ☐ Yes ☐ No

ALLERGIES

Allergy	Yes	No	Allergy	Yes	No	Allergy	Yes	No
Adhesive/Tape	☐ Yes	☐ No	Demerol	☐ Yes	☐ No	Metals/Jewelry	☐ Yes	☐ No
Anticoagulant Therapy	☐ Yes	☐ No	Iodine / Seafood	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Local Anesthetic/Novocain	☐ Yes	☐ No	Other_________________________		

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I will notify this office of any changes in my health status, insurance coverage or changes in the information provided. I give 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 Signature____ Date_______________

Revised 07/22/15