



PATIENT REGISTRATION

(CHILD)

North Shore Foot & Ankle

Please Print

Date _____

PATIENT INFORMATION

Patient Name _____ Age _____ Date of Birth _____
(Last) (First) (MI)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Other _____ Sex: M F

Ethnicity: Hispanic Non-Hispanic Race: African Amer. Amer. Indian Asian Caucasian Pacific Islander Other

Father's Name _____ Date of Birth _____

Address _____

Employer _____ Employer's Phone _____

Mother's Name _____ Date of Birth _____

Address _____

Employer _____ Employer's 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.

Parent/Responsible Party Signature _____ Relationship _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corn and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicines or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes-Type_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Adhesive/Tape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulant Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metals/Jewelry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Novocain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Demerol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seafood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> 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/Responsible Party Signature _____ Date _____