PATIENT REGISTRATION

(Please Print)

Date_____/_____/_____

PATIENT INFORMATION:

Patient Name_____ Sex: M☐ F☐
First Last Middle

Home Address_____ Apt#_____

City_____ St_____ Zip_____ Home Phone _____

Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐ Cell Phone _____

Date of birth_____/_____/_____ Age_____ Height _____ Weight _____  Size _____

Race: Am. Indian ☐Asian ☐Black ☐Caucasian ☐Pacific Islander ☐Other Race ☐Decline to Answer☐

Ethnicity: Hispanic ☐Non-Hispanic ☐Decline to Answer☐ *Primary Language:* _____

E-mail Address: _____

Employer _____ Social Security # _____

Occupation _____ Work Phone _____

In case of Emergency Contact _____Phone _____

Whom may we thank for referring you to this office _____

Which Dr. referred you to our office: _____

INSURANCE #1

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

INSURANCE #2

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medial or government benefits to the undersigned Physician or Supplier for services.

Signature _____ Date_____/_____/_____

PATIENT REGISTRATION

(Please Print)

PATIENT'S HEALTH HISTORY:

Foot Symptoms _____

_____

_____ When did symptoms begin _____

Family Doctor _____ Last Visit _____

Podiatrist _____ Last Visit _____

Pharmacy Name: _____

Pharmacy Address or phone number: _____
(For Address you may use the cross streets and zip code)

Check any illness or condition you have or have had:

DIABETES____ STROKE ____ EPILEPSY____ HEART DISEASE ____ ASTHMA____GALL BLADDER____

RHEUMATIC FEVER____ CANCER____ AIDS____ METAL IN BODY ____ CLAUSTROPHOBIA ____

ARTIFICIAL JOINT/IMPLANT____HIGH BLOOD PRESSURE____ KIDNEY____ DIALYSIS____

STOMACH PROBLEMS____ (G. I. Problems, Ulcers) Do you need an antibiotic before surgery Y____N____

Other Medical Conditions Not Listed Above: _____

_____

_____

Are you Pregnant Y_____ N_____ If you have recently given birth are you nursing? Y_____ N _____

PREVIOUS SURGERIES _____

_____

_____

MEDICATIONS AND VITAMINS TAKING: _____

_____

_____

Are you **ALLERGIC** to any medications: No____ Yes____ Please list_____

_____

_____

Do you use **TOBACCO** products: No ___Yes___ DAILY Amount _____

Do you drink **ALCOHOLIC** beverages: No ___Yes___ DAILY Amount _____

I certify that the above information is correct and best of my knowledge.

Signature_____ Date_____/_____/_____

Other Insurance Inquiry

Patient: _____

Are **you** covered by another health plan besides _____
Primary Insurance Name

Yes ☐ No ☐

If yes, you will need to provide our office with a copy of your card.

Name of Insurance Company: _____

Address: _____

Name of insured person: _____ Date of Birth: _____

Policy Number: _____ Effective Date: _____

Termination Date: _____ (if applicable)

_____ _____
Patient Signature Date

Encuesta de Otro Seguro Medico

Tiene **usted** otro plan de seguro medico aparte de _____
Nombre de aseguranza que es primaria

Si No

Si contesto “Si”, usted tiene que proporcionar nuestra oficina con una copia de la tarjeta.

Nombre del seguro medico _____

Direccion_____

Nombre de la persona asegurada _____ Fecha de nacimiento _____

Numero de póliza_____ Fecha de empiezo _____

Fecha de terminación_____ (Si es aplicable)

_____ _____
Firma del Paciente Fecha