Northside Foot Ankle, P.C.

PATIENT REGISTRATION FORM

(Please Print)

Chart # **Date / /**

PATIENT PERSONAL INFORMATION

Last Name	First Name	MI		__ Mr. __ Miss __ Mrs. __ Ms.	
Marital Status __Single __Married __Divorced __Separated __Widow(er)	Date of Birth / /	Age	Sex __M __F	Social Security # - -	Drivers License #
Ethnicity: __ Hispanic __ Non-Hispanic	Race: __ American Indian/Alaskan Native __ Asian __ Black/African American __ Hawaiian/Pacific Islander __ White __Other				Preferred Language:
Occupation:	Height:	Weight:	Shoe Type: __ Dress __ Work Boot __ Steel/Ceramic Toed __ Athletic Shoe __ Other		Shoe Size:

PATIENT CONTACT INFORMATION

Home Address _____

Apt # City State Zip Code + 4 Country

Cell Phone ___ Preferred (Area Code)	Home Phone ___ Preferred (Area Code)	Email:

Emergency Contact 1

Name Relationship Phone Number (Area code)

Emergency Contact 2

Name Relationship Phone Number (Area code)

Employer Name	Work Phone # (Area code)

Work Address _____

Apt # City State Zip Code County

PATIENT HEALTH SERVICES INFORMATION

Primary Care Physician Name:	Primary Care Phone (Area Code)

Primary Care Address _____

Apt # City State Zip Code

Pharmacy Name/ Address _____

Name City State Area Code

Referring Physician Name: ___Same as PCP		Referring Physician Phone (Area Code)

Referring Physician Address _____

Apt # City State Zip Code

Previous Podiatrist Name:	Problem Treated For:

Reason For Leaving Previous Podiatrist:

Reason for Visit:

___ Result of Auto Accident ___ Result of Injury while at Work Workman's Comp Claim #: _____

How did you hear about our practice: ___Google ____Zoc Doc ____ Phone Book ___ Insurance Company ___ Sign/Location

___ Physician Referral ____ Friend/Family Name:_____ Other:_____

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PATIENT INSURANCE INFORMATION

Primary Insurance Information

Name of Insurance	Policy/Group#	ID #	
Name of Insured	Employer Name	SS#	Date of Birth
Name of Care Holder	Employer Name	SS#	Date of Birth

Secondary Insurance Information

Name of Insurance	Policy/Group #	ID #	
Name of Insured	Employer Name	SS#	Date of Birth
Name of Card Holder	Employer Name	SS#	Date of Birth

PATIENT MEDICAL HISTORY

Medical history:__ Diabetes___# of years __ Renal Disease__ Dialysis __ Heart Disease __ Stroke __ Heart attack __ HIV __ Dementia
__ Hypertension __ High Cholesterol __ Sickle Cell __ Varicose Veins __ Hepatitis __ Neuropathy __ Arthritis __ Gout __ Blood Clots
Please specify any other medical conditions:

Allergies: __ None __ Penicillin __ Sulfa __ Codeine __ Iodine __ Latex __ Local Anesthetics __ NSAIDS __ Aspirin __ Food
Other: _____ Reaction type: _____

Medications and Vitamins Please List:

Are you currently taking: __ Coumadin __ Plavix __ Pletal __ Lovenox __ Aspirin

Past Surgeries: __ None __ Appendectomy __ Tonsilectomy __ Hysterectomy __ Stents __ Bypass Procedures __ Arthroscopy
__ Knee replacement __ Hip Replacement __ Back Surgery __ AV fistula __ Transplants __ Varicose Veins __Fracture Repair
Other: _____ Complications: __ Problems with anesthesia __ Blood Clots

Family History: __Heart Disease __ Stroke __ Diabetes __ Cancer __Rhematoid Arthritis
Please Specify other:

Social History: Do you use the following for ambulation: ___ Walker ___ Cane ___ Wheel Chair ___ Brace ___ Prosthetic
Tobacco: __ None __ Current __ History of Use # of Packs per day:_____ # of years: _____ When did you quit: _____
Alcohol: __ None __Current __History of abuse # Drinks per week: _____
Recreational Drug Use: __ None __ Current __ History of Use When did you quit:_____ What type:_____
Exercise Activities: __ Walking __ Running __ Bicycling __ Weight lifting __ Elliptical __ Swimming __ Yoga/Pilates
Other: _____ # times per week: _____
Living Situation: ___ Alone ___ Nursing Home ___ Caretaker ___ Family Other:_____

I hereby give my permission to the physician of Northside Foot & Ankle, P.C. to administer any non-surgical treatment that maybe necessary to treat my foot condition. I understand that I am financially responsible for all charges (whether or not covered by the insurance company). I understand it is my responsibility to be knowledgeable about my insurance plan and it's coverage. I understand that if I receive a check from my insurance company for services provided by Northside Foot & Ankle, P.C. I am responsible for paying Northside Foot & Ankle, P.C. immediately. **Co-Payments must be paid at the time of service.**

Signature: _____ Date: _____

I authorize the release of any medical information necessary to process my insurance claim. I authorize payment of Medical Benefits to Northside Foot & Ankle, P.C. (must sign prior to treatment). **We need copies of all Insurance cards/Driver's License/State ID**

Signature: _____ Date: _____