PATIENT REGISTRATION FORM

Last Name:_____ Date of Birth: _____

First Name: _____ Patient Gender: □ Male □ Female

Middle Name: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Address:_____ Race: _____

City, State, Zip:_____ Occupation: _____

Home Phone:(____) _____ □ Full Time □ Part Time □ Retired □ Disabled

Cell Phone: (____)_____ Employer: _____

Work Phone: (____)_____ Address: _____

Social Security: _____ City, State, Zip: _____

Email Address: _____ Phone: (____)_____

Whom may we thank for referring you to our practice?
□ Family/Friend □ Physician Referral □ Website □ Advertisement □ Insurance □ Other: _____

Family/PCP Physician:
Name: _____
Address:_____
City, State, Zip: _____
Phone: (____)_____
Date last seen: _____

Pharmacy:
Name: _____
Address: _____
City, State, Zip: _____
Phone#:(____)_____

Please check all methods we may utilize to speak with you or to leave you a detailed message:

	Appointment Information	**Medical Information**
Phone (including auto calls)	□ Home □ Cell □ Work	□ Home □Cell □ Work
TEXT / Email / Patient Portal:	□	□
Send Via Mail	□	□
With another Person(s):	□	□

**** Please sign separate designation for release of medical information form***

Emergency Contact: ******Please list name of someone* **NOT** *living in your household******

Name:_____ Relationship to Patient: _____

Phone: (____) _____ □ Home □ Cell □ Work

Do you have an advance care plan or surrogate decision maker? □ No □ Yes

Name of custodian of document: _____

Complete Foot and Ankle Specialists, Inc. does not honor advanced directives.
We will call 911 to provide life support to any patient in distress.

After treatment, the patient will be turned over to their treating physician for continuing care and we will provide them with the name of your custodian of document you listed above.

INSURANCE INFORMATION:

**** Insurance Card(s) and photo ID must be given to front desk at time of service ****

Will this treatment be done as a result of?

- **Workers Compensation Injury:** □ No □ Yes Date of Injury: _____

  Do you have a first report of injury? □ No □ Yes Physician of Record: _____

  WC Claim #: _____ Managed Care Organization: _____

  Claims Representative: _____ Phone #:(____)_____

- **Auto/Personal Accident:** □ No □ Yes Date of Injury: _____

  Claim #: _____ Auto/Homeowners Insurance: _____

  Claims Representative: _____ Phone #:(____)_____

****

***Primary* Insurance**: _____ Referral Required □ No □ Yes

Policy/ID #:_____ Group #:_____

Insured/Subscriber: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Insured Employer:_____

***Secondary* Insurance**: _____ Referral Required □ No □ Yes

Policy/ID #:_____ Group #:_____

Insured/Subscriber: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Insured Employer:_____

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Complete Foot and Ankle Specialists, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non - covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the release of my medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform Complete Foot and Ankle Specialist, LLC if there is a change in my health insurance information.

I hereby give permission to Complete Foot and Ankle Specialists, LLC to examine, photograph, administer treatment and perform such minor operative procedures as may be deemed necessary in the diagnosis of my foot problem.

Signature _____ Date _____

(If the patient is a minor, the legal guardian must sign)

Patient Name:_____ Date of Birth:_____

PATIENT MEDICAL INFORMATION

Patient Name:_____ **Date of Birth:**_____

To help us meet your health care needs, please complete the following questionnaire.

Describe your foot/ankle problem (example: right ankle pain):

_____

When did this begin? _____

Was there an accident or injury? □ No □ Yes, please describe _____

How painful is your condition? (Scale: 0 = no pain 10 = extremely painful)

Please check one: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10

Type of pain: □ Burning □ Tingling □ Sharp □ Dull Ache □ Shooting □ Stabbing □ Numbness □ Throbbing

When does the pain occur? □ Standing □ During walking □ After walking □ During sports

□ With shoes □ Without shoes □ Worse with activity □ Better after activity □ ALWAYS

What makes the pain/condition better (Example: rest, icing, medications, etc.)? _____

_____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **□ Men's □ Women's**

Smoker? □ No □ Yes, how long? _____ How many packs a day? _____ Quit_____

Vaping? □ No □ Yes, how long? _____ How often? _____ Quit_____

Alcohol use? □ No □ Yes, how often? □ Weekly □ Occasionally □ Rarely

Drug use? □ No □ Yes, what type? □ Marijuana □ Illegal Prescription, what type? _____

□ Other: _____

Have you gotten a flu vaccine this season? □ No □ Yes, Date: _____

Have you gotten a pneumonia vaccine within the last 5 years? □ No □ Yes, Date: _____

PAST MEDICAL HISTORY: Have you ever **HAD or HAVE** any of the following:

□ Arthritis □ Back Problems □ Cancer □ Colitis □ Depression □ Dermatitis □ Peptic Ulcer

□ Asthma □ Bleeding Disorder □ Heart Disease □ Kidney Disease □ Lung Disease □ HIV+

□ High Cholesterol □ Hepatitis □ Venous Disease □ Artificial Valves or Joints □ Gout

□ High Blood Pressure □ Rheumatoid Arthritis □ Osteoarthritis □ Circulatory Problems

□ Pneumonia □ Thyroid Disease □ Tuberculosis □ Diabetes-Type 1 □ Diabetes-Type 2

□ Gallbladder Problems □ Neuropathy

□ Any other medical problems not listed above: _____

□ **NONE OF THE ABOVE**

Patient Name:_____ **Date of Birth:**_____

Past **SURGERIES** with date:

_____

_____

_____

_____

Past **HOSPITALIZATIONS** with date:

_____

_____

_____

_____

REVIEW OF SYMPTOMS: Are you **CURRENTLY** experiencing any of the following:

GENERAL: □ Chills □ Fever □ Unexplained Weight Gain □Unexplained Weight Loss

EYES: □ Eye symptoms

EARS/NOSE/THROAT/MOUTH: □ Ear Symptoms □ Nasal Symptoms □ Throat/Mouth Symptoms

CARDIOVASCULAR: □ Chest Pain □ Cold Feet □ Numbness/Tingling in Feet □ Rest Pain
□ Pain in calf's when walking □ Stiffness in joints □ Swelling of legs
□ Swelling of feet □ Swelling of ankles □ Non-healing ulcer □ Vein problems

RESPIRATORY: □ Shortness of breath □ Cough □ Congestion

GI: □ Changes in appetite □ Constipation □ Diarrhea □ Indigestion □ Nausea □ Ulcers □ Vomiting

GU: Urinary frequency □ Excessive urination □ Pain with urination

MUSCULO: □ History of falls □ Leg cramps □ Muscle aches □ Tenderness

SKIN: □ Skin symptoms □ Hair symptoms □ Nail symptoms

NEUROLOGIC: □ Difficulty with balance □ Headache □ Lightheadedness □ Restless leg syndrome
□ Stroke

PSYCHIATRIC: □ Anxiety □ Insomnia □ Memory loss □ Mood changes

ENDOCRINE: □ Dry Skin □ Hair loss □ Excessive sweating □ Excessive thirst □ Thyroid problems

HEMA/LYMPH: □ Excessive bleeding □ Bruising

FAMILY HISTORY: Has any member of your immediate family been treated for the following?

	MOTHER	FATHER	GRANDMOTHER	GRANDFATHER
□ Arthritis	□	□	□	□
□ High Blood Pressure	□	□	□	□
□ Cancer	□	□	□	□
□ Heart Disease	□	□	□	□
□ Diabetes				

Type I	☐	☐	☐	☐
Type II	☐	☐	☐	☐
☐ UNKNOWN	☐	☐	☐	☐

Patient Name:_____ **Date of Birth:**_____

MEDICATIONS: Are you currently taking any medications? (*Please ATTACH list if needed)*

☐ **NONE AT THIS TIME**

	Name of Medication	Strength	Dosage	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

ALLERGIES: Please **CHECK** any of the following to which you've had **ALLERGIC REACTIONS** to:

☐ **NO KNOWN DRUG ALLERGIES**

☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetics (Novocain) ☐ Penicillin ☐ Sulfur

☐ Adhesive ☐ OTHER: _____