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PATIENT REGISTRATION FORM

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Sex: M F Date of Birth: _____ SSN: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Address: _____

Primary Physician: _____ Phone Number: _____

Emergency Contact:

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

Health Coverage:

Primary Insurance: _____ Member ID#: _____

Secondary Insurance: _____ Member ID#: _____

Subscriber's Name (if not self): _____ DOB: _____

Subscriber's SSN: _____ Relationship: _____

How did you hear about our office? _____

Internet/Google Friend/Family* Doctor Referral*

Insurance Company* Facebook

(*who) _____

Other _____



SHOE SIZE:

PATIENT HEALTH HISTORY

Please describe your problem: _____

Do you have pain? Y N When did it start? _____

If so, where is it located? _____

Describe its quality? (stabbing, shooting, burning) _____

How severe is it? (mild, moderate, severe): _____

How long does it last? _____

Do shoes make it better or worse? _____

What medications are you taking? _____

What surgeries have you had in the last 5 years? _____

Is there a family history of diabetes? Y N

Is there a family history of heart disease? Y N

Is there a family history of lung cancer? Y N

Do you smoke? Y N Do you drink alcohol? Y N

Do you wear glasses or contacts? Y N

Any fever or unexplained weight loss the last year? Y N

Any numbness or tingling in your toes or feet? Y N

Any history of stomach ulcers or problems? Y N

Any history of arthritis or joint pain? Y N

Are you pregnant? Y N If yes, how far along? _____

Are you allergic to any of the following?:

Adhesive Tape Penicillin Local Anesthetic (Novocain)

Please list any other allergies that you have: _____

Do you have any of the following?:

____ Heart Disease

____ AIDS or HIV

____ Circulatory Disease

____ Diabetes

____ Kidney Trouble

____ High Blood Pressure

____ Gout

____ Hepatitis

____ Mental Health Problems

____ Liver Trouble

____ Others