

## Patient Registration Form

Completed forms should be submitted to our office 48 hours prior to your appointment. All forms can be faxed to our confidential fax at 954-481-1620.

### Patient Information (PLEASE complete all applicable spaces)

Full First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Alternate/Billing Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Best time and place to reach you: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M/F Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer Name/Address: \_\_\_\_\_ or Student: Yes/No  
Chief Complaint: \_\_\_\_\_ Occurrence Date: \_\_\_\_\_ Related to: Work: Yes/No Auto: Yes/No Accident: Yes/No  
Full Name of Family Doctor: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: \_\_\_\_\_ If necessary did you bring your referral: Yes/No/NA  
Insurance Phone # for eligibility: \_\_\_\_\_ Claims address: \_\_\_\_\_  
Policy/Member ID: \_\_\_\_\_ Group/Account #: \_\_\_\_\_  
Primary Insured's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M/F SS #: \_\_\_\_\_  
Primary Insured's home address: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

### Secondary Insurance (ONLY if patient has Medicare as a primary/secondary)

Insurance Name: \_\_\_\_\_ If necessary did you bring your referral: Yes/No/NA  
Insurance Phone # for eligibility: \_\_\_\_\_ Claims address: \_\_\_\_\_  
Policy/Member ID: \_\_\_\_\_ Group/Account #: \_\_\_\_\_  
Primary Insured's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M/F SS #: \_\_\_\_\_  
Primary Insured's home address: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

### Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Names of family/friends who can pick up your records and/ medical supplies: \_\_\_\_\_  
Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:  
\_\_\_\_\_

### Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Doctors at Foot and Ankle Associates of North Texas.

Printed Patient's Name: \_\_\_\_\_ Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History

## General History

Full Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Gender: (circle) M or F Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: \_\_\_\_\_  
Chief Complaint: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Last Seen: \_\_\_\_\_  
Would you say your health is: Good/Fair/Poor. Do you think you might be pregnant? Yes/No  
Smoking: Packs/day: \_\_\_\_\_ Years: \_\_\_\_\_ Past Smoker: Packs/day \_\_\_\_\_ Years: \_\_\_\_\_  
Caffeine: Quantity \_\_\_\_\_ Alcohol: None Rarely Moderately Daily Quit  
Recreational Drug Use: None Moderately Daily Quit  
List Athletic activities: \_\_\_\_\_ Amount per day/week: \_\_\_\_\_  
Employment requires you to: (circle which apply) Sit Stand Sit and Stand Stand and Walk Not Employed  
Have you ever been to a Podiatrist before: Yes/No. If yes, please list. Name: \_\_\_\_\_ Last Seen: \_\_\_\_\_  
Have you ever worn orthotics/arch supports? Yes/No. If yes, what kind: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## History Of : Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Chest Pain	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chemical Dependency	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Cancer	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in Ankles/Feet
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints	Depression	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes	High Blood Pressure	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss, unexplained

Sensation History: Night Pain Burning Tingling Swelling Cramps/Numbness in Feet or Legs Calf Pain

**Pain Level:** Please circle the number on the pain scale that best represents your level of pain at this moment.

0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10  
(zero: NO Pain) (ten: Worst possible pain)

## Family History

List Relationship to you of family members who have had: Foot Problems: \_\_\_\_\_  
Arthritis: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Heart Problems: \_\_\_\_\_

## Past Surgical Procedures/other Hospitalization:

Surgical History	Date	Hospitalization History	Date
_____	_____	_____	_____
_____	_____	_____	_____

Previous Blood Transfusions: Yes/ No

Exposure to Hepatitis: Yes/ No

## Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: _____	Anticoagulants: _____	Aspirin: _____
Codeine: _____	Demerol: _____	Iodine: _____
Local Anesthetics: _____	Novocain: _____	Penicillin: _____
Seafood: _____	Sulfa: _____	Other: _____

Print Patient's Name: \_\_\_\_\_ Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_