PREMIER FOOT & ANKLE CARE PATIENT REGISTRATION

Patient Full Name:		Gender: ❑ Male ❑ Female ❑ Transgender	
Soc Sec #:	Date of Birth:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Preferred Phone: ❑Home ❑Cell ❑Work	Email Address:		

❑ **Check here** to authorize text messages for appointment reminders and information about your healthcare

Marital Status: ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

Race: ❑American Indian/Alaska Native ❑ Asian ❑Native Hawaiian ❑Black/African American ❑ White ❑Hispanic ❑Other Race ❑Other Pacific Islander

Ethnicity: ❑ Not Hispanic/Latino ❑Hispanic/Latino

Employer:	Employer Phone:		
Emergency Contact:	Relationship**:**	Phone #:	

Responsible Party (if other than self)

Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other Please list -

Address:	City:	State:	Zip:
DOB:	Soc Sec #	Primary Phone #:	

INSURANCE INFORMATION

Primary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:
Secondary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:
Tertiary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:

I hereby give permission for Premier Foot & Ankle Care to render the proposed Podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefits due to Premier Foot & Ankle Care to be paid directly to Premier Foot & Ankle Care.

I hereby give my permission for Premier Foot & Ankle Care to forward any pertinent medical information to my primary or referring physician for continuity of care.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either me or my insurance company in writing.

The above information is true and I will notify Premier Foot & Ankle Care of any changes.

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Primary Care Physician / Pharmacy / Personal Information

Primary Care Physician:		Phone#:	
Date last seen:			
Height:	**Weight:**	**Shoe size:**	**Shoe width:**
Primary Pharmacy Name:			
Address:	City:	State:	Zip:
Phone #:			

MEDICAL HISTORY

Do you have Diabetes: ❑ **YES** ❑ **NO**	**If yes, How long:**	
How do you control your Diabetes: ❑ DIET	❑ INSULIN	❑ OTHER MEDICATION
What was your last Blood Sugar Level / or A1C:		

PLEASE CIRCLE ALL THAT APPLY

AIDS/ HIV	❑Self	❑Family	HEPATITS (A / B /C)	❑Self	❑Family
ANEMIA	❑Self	❑Family	HIGH BLOOD PRESSURE	❑Self	❑Family
ANXIETY	❑Self	❑Family	HIGH CHOLESTEROL	❑Self	❑Family
ARTHRITIS (GENERALIZED)	❑Self	❑Family	KIDNEY DISEASE	❑Self	❑Family
ASTHMA	❑Self	❑Family	MENTAL DISEASE	❑Self	❑Family
BLEEDING DISORDER	❑Self	❑Family	OSTEOPOROSIS	❑Self	❑Family
BLOOD CLOTS	❑Self	❑Family	POOR CIRCULATION	❑Self	❑Family
CANCER	❑Self	❑Family	RHEUMATOID ARTHRITIS	❑Self	❑Family
DEPRESSION	❑Self	❑Family	STD / STI	❑Self	❑Family
EPILEPSY / SEIZURES	❑Self	❑Family	STROKE	❑Self	❑Family
FIBROMYALGIA	❑Self	❑Family	S THYROID - HIGH	❑Self	❑Family
GOUT	❑Self	❑Family	THYROID - LOW	❑Self	❑Family
HEADACHES	❑Self	❑Family	TUBERCULOSIS	❑Self	❑Family
HEARING PROBLEMS	❑Self	❑Family	VEIN DISORDER	❑Self	❑Family
HEART DISEASE	❑Self	❑Family	Other:		
PLEASE LIST OTHERS:					

HISTORY OF ANY SURGERIES / ACCIDENTS:

Surgeries/Accidents	Year	Surgeries/Accidents	Year

PREMIER FOOT & ANKLE CARE PATIENT REGISTRATION

CURRENT MEDICATION LIST

*******IF YOU HAVE A MEDICATION LIST PLEASE GIVE TO THE FRONT DESK TO COPY*******

NAME OF MEDICATION	Dosage	NAME OF MEDICATION	Dosage
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

ALLERGIES / REACTIONS *PLEASE ADD YOUR REACTION*:

NAME	REACTION	NAME	REACTION	NAME	REACTION
❑ No Allergies		❑ Latex		❑ Tetracycline	
❑ Aspirin		❑ Demerol			
❑ Codeine		❑ Sulfa			
❑ Cortisone		❑ Tape/Adhesives			
❑ Iodine		❑ Penicillin			
❑ Keflex		❑ Cipro			

FAMILY HISTORY

NAME	LIVING OR DECEASED	DOB & AGE	ADULT ILLNESS
FATHER	❑Living ❑Deceased		
MOTHER	❑Living ❑Deceased		
BROTHER (S)	❑Living ❑Deceased		
SISTER (S)	❑Living ❑Deceased		

SOCIAL HISTORY

Do you smoke? ❑Yes ❑No	Have you ever smoked? ❑Yes ❑No	If quit when:
Do you drink alcoholic beverages? ❑Yes ❑No	How much/often?	Occupation:
I live with: ❑ No One ❑ Spouse ❑ Children ❑ Parents ❑ Other:		
I stand _____ % of my day	I exercise each week: ❑ 0 days ❑1-2 days ❑ 3-4 days ❑ 5+ days	Sports/Activities:

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REVIEW OF SYSTEMS

General	Hematology	Vascular	Cancer	GI	Respiratory	Psychiatric
Fever ❑	Poor healing ❑	Pain in legs ❑	Melanoma ❑	Nausea ❑	Chronic cough ❑	Anxiety ❑
Chills ❑	Easy bruising ❑	Cramps while walking ❑	Basal cell ❑	Vomiting ❑	Shortness of breath ❑	Depression ❑
Fatigue ❑	**Endocrine**	Cramps at night ❑	Squamous cell ❑	Acid reflux ❑	**Ears**	Mood swings ❑
Skin ❑	Increased urination ❑	Varicose veins ❑	**Musculoskeletal**	Diarrhea ❑	Dizziness ❑	Dementia ❑
Rashes ❑	Increased thirst ❑	**Urinary**	Muscle pain ❑	Constipation ❑	Difficulty hearing ❑	**Cardiac**
Itching ❑	**Neurology**	Kidney failure ❑	Back pain ❑	**Eyes**		Leg swelling ❑
Sores ❑	Numbness ❑	Frequent urination ❑	Muscle spasms ❑	Blurred vision ❑		Chest pain ❑
	Tingling ❑		Joint pain/stiffness ❑	Blindness ❑		
	Burning sensation ❑					

REASON FOR VISIT

Chief Complaint:

Which foot/ankle is involved? ❑ Right ❑ Left ❑ Both

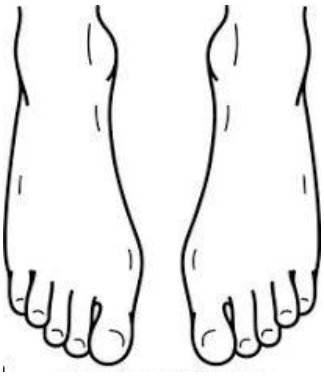
When did the problem begin:

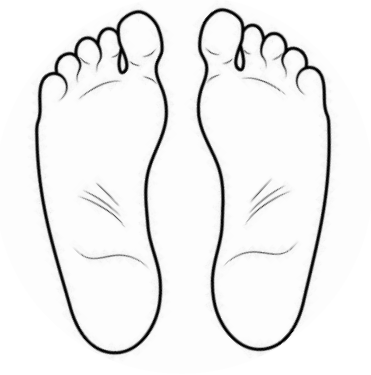
What treatments have you tried if any:

Have you seen another Doctor for this condition: Yes No

If yes, Who did you seek treatment from:

Please Circle Where Your Pain Is:





Describe the pain: ❑Sharp ❑Dull ❑Aching ❑Throbbing ❑Cramping ❑Itching ❑Popping ❑Burning ❑Tingling ❑Clicking ❑Shooting ❑Stabbing ❑Other:

PAIN LEVEL 1-10: 0 1 2 3 4 5 6 7 8 9 10

Who Referred you to us:

Signature_____ Date_____