Patient Registration

Patient Details

Title: Dr. Mr. Mrs. Ms.

Name: (First) _____ (Middle) _____ (Last) _____

Reason for visit: _____

Is this related to an accident or injury? YES NO If yes notify the scheduling department prior to scheduling the appointment.

Pharmacy Name: _____ Location (city): _____

Date of Birth: ____/____/____ Male Female

Marital Status: Married Single Widowed Divorced Social Security#: _____

Primary Doc: Middleton Dang Mayembe Referring Provider: _____

State Issued Picture ID must be brought to the appointment. If the patient is a minor the parent's Picture ID must be obtained.
Patient instructed on this: YES NO

Address Tab

Address: _____ Apt#:_____

City: _____ State: _____ Zip: _____

Home phone#:_____ Cell phone#:_____ Work phone#:_____

Email: _____ Can we leave a message on answering machine? _____

Contacts Tab

Employer Details:

Employment Status: Full Time Unemployed Self Employed Retired Part Time Student Active Military

Employer Name: _____ Phone #: _____

Occupation: _____

Emergency Contact Details:

Name: _____ Relation: _____

Phone number: _____ Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Spouse/Parent/Legal Guardian information

Name: _____ Phone number: _____

Address: _____

Relation: _____ SSN: _____

Date of Birth: _____/_____/_____ Employer _____

Other Info. Tab

Preferred Language: _____ Race: _____ Ethnicity: Hispanic Non-Hispanic

Physicians Tab

Additional doctors who are managing the patient's care (list name and type of doctor) _____

_____

_____

Insurance Information

Primary

Insurance Carrier: _____ Primary Holder: _____

Date of Birth: _____/_____/_____ Social Security#: _____

Insurance ID#: _____ Group#: _____

STAFF ONLY: You will also need to put this insurance in a second time and mark as DMERC.

Secondary

Insurance Carrier: _____ Primary Holder: _____

Date of Birth: _____/_____/_____ Social Security#: _____

Insurance ID#: _____ Group#: _____

STAFF ONLY: If Medicare is secondary you will need to put in Cigna Government as a secondary as well, with the same ID#.

STAFF ONLY: Is a referral needed? YES NO Referral has been obtained (Initial) _____

STAFF ONLY: Insurance has been checked and is active (Initial) _____

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Medical History:

AIDS/HIV	YES	NO	KIDNEY PROBLEMS	YES	NO
ANEMIA	YES	NO	LIVER DISEASE	YES	NO
ANGINA	YES	NO	LOW BLOOD PRESSURE	YES	NO
ARTIFICAL HEART VALVES	YES	NO	NEUROPATHY	YES	NO
ASTHMA	YES	NO	PHLEBITIS	YES	NO
BACK PROBLEMS	YES	NO	RADIATION TREATMENT	YES	NO
BLEEDING DISORDERS	YES	NO	RASH	YES	NO
CHEMICAL DEPENDENCY	YES	NO	RESPIRATORY DISEASE	YES	NO
CHEST PAIN	YES	NO	RHEUMATIC FEVER	YES	NO
CHRONIC DIARRHEA	YES	NO	SHORTNESS OF BREATH	YES	NO
CIRCULATORY PROBLEMS	YES	NO	SINUS PROBLEMS	YES	NO
DIABETES	YES	NO	SPECIAL DIET	YES	NO
EAR PROBLEMS	YES	NO	STROKE	YES	NO
EYE PROBLEMS	YES	NO	SWELLING IN ANKLE	YES	NO
FAINTING	YES	NO	SWELLING IN FEET	YES	NO
FOOT/LEG CRAMPS	YES	NO	SWOLLEN NECK GLANDS	YES	NO
EPILEPSY	YES	NO	TIRED FEET	YES	NO
GOUT	YES	NO	TUBERCULOSIS	YES	NO
HEADACHES	YES	NO	ULCERS	YES	NO
HEART DISEASE	YES	NO	VARICOSE VEINS	YES	NO
HEMOPHILIA	YES	NO	VENEREAL DISEASE	YES	NO
HEPATITIS/JAUNDICE	YES	NO	WEIGHTLOSS UNEXPLAINED	YES	NO
HIGH BLOOD PRESSURE	YES	NO			

Please list any medical conditions not mentioned above: _____

_____

Are you currently experiencing or have experienced in the past any of the following:

Ankle pain	Athlete's Foot	Corns or Callus	Bunions	Flat Feet	Heel pain
Ingrown nails	Plantar warts	Numbness in feet or legs			

ALLERGIES

ADHESIVE TAPE	YES	NO	DEMOROL	YES	NO	LOCAL ANESTHETICS	YES	NO
ANTICOAGULANTS	YES	NO	IODINE	YES	NO	SEAFOODS	YES	NO
ASPIRIN	YES	NO	NOVOCAINE	YES	NO	SULFA DRUGS	YES	NO
CODEINE	YES	NO	PENICILLIN	YES	NO	Other: _____		

SURGERIES: _____

_____

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICATIONS: (List all medications taken. If the patient cannot provide this information contact pharmacy to get list)

_____

_____

_____

Do you take oral contraceptives? YES NO

FAMILY HISTORY: (Circle any that apply and list the relation to the patient to the right. This is immediate family only; mother, father, sister, brother, daughter and/or son)

HEART DISEASE_____ DIABETES_____ ARTHRITIS_____ OTHER: _____

HYPERTENSION_____ CANCER_____ STROKE_____

SOCIAL HISTORY:

Last Nail care: _____ Diabetic: NO YES Last Vascular Study: _____ Last CDFE: _____

Tobacco use: NEVER CURRENT USE QUIT for _____ If yes type: _____

Have you ever been hospitalized for anything other than surgery? YES NO

Illicit drug use: NEVER USED HISTORY OF USE CURRENT USE

Are you under the care of Pain Management? YES NO

IV Drug use: NEVER USED HISTORY OF USE CURRENT USE

Occupational exposure to chemicals or toxins? NONE CURRENT EXPOSURE HISTORY OF EXPOSURE

Alcohol use: YES NO If yes how often: _____

Are there any activities that you participate in on a regular basis? YES NO If so what type: _____

_____

Have you ever been seen by a Podiatrist before? YES NO If so list who and the reason: _____

_____

If the patient is a diabetic, how often do they check their blood sugars? _____

How are they controlled? _____ What is the normal range? _____

Are you under the care of any other physicians? YES NO If yes list reason: _____

_____

Will you arrive at your appointments by transportation? YES NO

If yes which transport company: _____

STAFF ONLY: If the patient will travel by transportation you MUST make an alert with this information. The patient can ONLY be scheduled as the first patient in the morning (9:00am) OR the first patient after lunch (1:30pm).

STAFF OFNLY: Alert has been put in with this information (initial) _____

Signature: _____ Date: _____