



REGISTRATION FORM

(Please give insurance card(s) and photo ID to our Front Office Team)

Name (First): _____ (Last): _____ (MI): _____ (Nickname): _____

DOB: _____ Sex: M F **Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred: Home Cell

PATIENT PORTAL - Secure, confidential and EASY to use website to access your:

*Medical Records *Pay Your Bills *Request Rx Refills *Request Appointments *Receive Appointment Reminders

Please provide your E-MAIL if you are interested: _____

Would you like to receive our Educational Newsletter via email? Yes No

Ethnicity:

- Not Hispanic or Latino
- Hispanic or Latino

Language:

- English
- Spanish
- Other

Race:

- African American
- American Indian/ Alaska Native
- Asian

- Native Hawaiian/Pacific Islander
- Unknown
- White/Caucasian
- Other

Marital Status: (Circle one)

S M W D

Student Status:

Full Time Part Time N/A

Employment Status:

Full Time Part Time N/A

How did you hear about us?

- Drive by
- Established patient
- Friends/Family
- Insurance
- Internet/Website
- Other: _____
- Referral from another patient
- Provider: _____

Primary Care Physician: _____ **Date Last Seen:** _____

Billing Information:

Payment Information / Responsible Party: (If other than patient) N/A Self-Pay

**Adult accompanying minor (17 years of age or younger) is responsible party*

Responsible Party: _____ **DOB:** _____ **Social Security #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Phone:** _____

***If self-pay or no SSN given when it's required by your insurance company, Payment in full is expected at time of service**

Primary Insurance

Insurance Name: _____
 Subscriber Name: _____
 Date of Birth: _____
 Subscriber ID: _____
 Group #: _____

Secondary Insurance

Insurance Name: _____
 Subscriber Name: _____
 Date of Birth: _____
 Subscriber ID: _____
 Group #: _____



Patient Name: _____

DOB: _____

PROBLEM 1:

Briefly describe the reason for your visit:

In which foot/ankle is the problem/pain: Left Right Both Foot Ankle

When did the problem/pain start: (# of) Days Weeks Months Years

Problem/pain occurs: While walking While not walking While standing First thing in the AM

Pain/discomfort can be described as: Shooting Throbbing Sharp Burning
 Dull/Aching Tender Tingling Numb None of these

Previous/current treatments: Anti-inflammatories Antibiotics Physical Therapy Bracing
 Over-the-counter orthotics Custom orthotics Surgery Doctor visit Other:

What is/are your goal(s) for treatment:

PROBLEM 2: (If applicable)

Briefly describe the reason for your visit:

In which foot/ankle is the problem/pain: Left Right Both Foot Ankle

When did the problem/pain start: (# of) Days Weeks Months Years

Problem/pain occurs: While walking While not walking While standing First thing in the AM

Pain/discomfort can be described as: Shooting Throbbing Sharp Burning
 Dull/Aching Tender Tingling Numb None of these

Previous/current treatments: Anti-inflammatories Antibiotics Physical Therapy Bracing
 Over-the-counter orthotics Custom orthotics Surgery Doctor visit Other:

What is/are your goal(s) for treatment:

What is your current shoe size: _____ **Usual shoe style:** _____

Have you fallen twice or more in the last year? Yes No

Please describe: _____

Are you diabetic? Yes No

What was your last A1c: _____ **Fasting blood sugar today:** _____

Which physician manages your diabetes: _____

Height: _____ **Weight:** _____



Patient Name: _____

DOB: _____

Preferred Pharmacy: _____

Medications:

Medication Allergies: N/A

- Adhesive tape Aspirin Iodine Local anesthetic Penicillin Suture
 Antibiotics Codeine Latex Morphine Sulfa Drugs Other: _____

Medical History:

Please indicate if you have/had any of the following conditions:

- | | | | | |
|---|---|---|---------------------------------------|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> COPD | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> MS | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> DVT (Blood clot) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cardiovascular History | <input type="checkbox"/> GERD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Urinary Infections |

Review of Systems:

Please indicate if you are currently having any of the following symptoms:

General:	<input type="checkbox"/> N/A <input type="checkbox"/> Nausea <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Vomiting <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness
Cardiovascular:	<input type="checkbox"/> N/A <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Leg/ankle swelling <input type="checkbox"/> Pain in legs while walking <input type="checkbox"/> Cramping in legs while walking
Gastrointestinal:	<input type="checkbox"/> N/A <input type="checkbox"/> GERD/heartburn <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> GI bleeding
Endocrine:	<input type="checkbox"/> N/A <input type="checkbox"/> Hyperglycemia/Diabetes
Musculoskeletal:	<input type="checkbox"/> N/A <input type="checkbox"/> Unstable walking <input type="checkbox"/> Poor balance <input type="checkbox"/> Falls <input type="checkbox"/> Low back pain <input type="checkbox"/> Joint pain/swelling feet <input type="checkbox"/> Joint pain/swelling ankles
Neurological:	<input type="checkbox"/> N/A <input type="checkbox"/> Numbness feet/legs <input type="checkbox"/> Burning feet/legs <input type="checkbox"/> Tingling feet/legs <input type="checkbox"/> Sciatica/radiating nerve pain from spine

Surgical History:

Do you have any artificial joints or heart valves? Yes No

If yes, please describe: _____

List any other lower extremity or cardiovascular surgeries: _____



Family History:

Please indicate if your mother or father had any of the following disorders:

- | | | |
|--------------|---------------------------------|---------------------------------|
| Arthritis | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Hypertension | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |

Social History:

Are you pregnant? N/A No Yes

Occupation: _____ **Employer:** _____

Do You Smoke? No Yes (How much do you smoke per day?): _____

If no, have you ever smoked? No Yes (Date quit): _____

I certify the information given is accurate to the best of my knowledge.

Patient Signature
(Authorized Representative)

DOB

Date of Visit