PATIENT REGISTRATION

FORM A-9

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name Last	First		Middle	
Parent if Patient is a Minor	Today's Date	Date of Birth	Sex	Age
Patient's Social Security Number	California Driver's License No.			
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number	Work Telephone Number			
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer			
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
Email Address:				
NOTIFY IN CASE OF EMERGENCY				
Name	Relationship			
Home Telephone	Work Telephone			
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name	Telephone			
Address	City	State	Zip	
Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:				
Secondary Insurance	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Were You Injured on the Job? YES NO	Have you Informed Your Employer? YES NO			
Date of Original Injury:				
Worker's Compensation Carrier Name	Address			

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

Describe your foot problem:

How long has it been bothering you? Days Weeks Years

Any past problems of your feet and ankles?

Any past surgical procedures

Shoe size Current Weight Height

Are you allergic Any Medicines?

Tape? Betadine (iodine)? Other?

Have you had problems taking aspirin or ibuprofen (Advil, Motrin)? Yes No

Any problems with local anesthetics (Novocaine, Lidocaine)? Yes No

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes No If yes, do you take insulin? Yes No Number of years?

Have you had any serious illnesses?

Are you under a physician's care? Yes No If yes, for what condition?

Physician Date you last saw this Doctor

May we contact your physician about your health? Yes No

Name of Pharmacy or Drug Store Phone #

What medications do you take regularly?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS:

Do you have any artificial joints?

Hip Yes No

Knee Yes No

Other _____

Do you have Heart Valve Implant? Yes No

FAMILY HISTORY:

Mother Living Deceased Cause of Death _____

Father Living Deceased Cause of Death _____

Brother Living Deceased Cause of Death _____

Sister Living Deceased Cause of Death _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

Signature Date

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature