PATIENT REGISTRATION

(Please Print)

Date_____/_____/_____

PATIENT INFORMATION:

Patient Name____ Sex: M____F____
First Last Middle

Home Address____ Apt#_________

City___________________________ St______ Zip________ Home Phone ____________________

Single ___Married ___Widowed ___Separated ___Divorced ___ Cell Phone ______________________

Date of birth______/______/______ Age_______ Height ______ Weight _______ Size _________

Race: Am. Indian ___Asian ___Black ___Caucasian ___Pacific Islander ___Other Race ___Decline to Answer___

Ethnicity: Hispanic ___Non-Hispanic ___Decline to Answer___ *Primary Language:* ______________________

E-mail Address: ____

Employer ______________________________________ Social Security # ______________________

Occupation ________________________________ Work Phone ______________________________

In case of Emergency Contact _____________________________Phone ______________________

Whom may we thank for referring you to this office ____

Which Dr. referred you to our office: ____

INSURANCE #1

Member Name ____ Date of birth _____/______/_____

Social Security # _____________________________ Relationship to Patient ________________________

Employer_______________________________ Insurance Company____________________________

INSURANCE #2

Member Name ____ Date of birth _____/______/_____

Social Security # _____________________________ Relationship to Patient ________________________

Employer_______________________________ Insurance Company____________________________

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medial or government benefits to the undersigned Physician or Supplier for services.

Signature ____ Date______/______/______

PATIENT REGISTRATION

(Please Print)

PATIENT'S HEALTH HISTORY:

Foot Symptoms ____

____

____ When did symptoms begin ________________________

Family Doctor ____ Last Visit ______________________

Podiatrist ____ Last Visit ______________________

Pharmacy Name: ____

Pharmacy Address or phone number: ____

(For Address you may use the cross streets and zip code)

Check any illness or condition you have or have had:

DIABETES____ STROKE ____ EPILEPSY____ HEART DISEASE ____ ASTHMA____GALL BLADDER_____

RHEUMATIC FEVER_____ CANCER_____ AIDS____ METAL IN BODY _____ CLAUSTROPHOBIA _____

ARTIFICIAL JOINT/IMPLANT____HIGH BLOOD PRESSURE_____ KIDNEY_____ DIALYSIS_____

STOMACH PROBLEMS____ (G. I. Problems, Ulcers) Do you need an antibiotic before surgery Y____N____

Other Medical Conditions Not Listed Above: ____

____

____

Are you Pregnant Y______ N______ If you have recently given birth are you nursing? Y_____ N _____

PREVIOUS SURGERIES ____

____

____

MEDICATIONS AND VITAMINS TAKING: ____

____

____

Are you **ALLERGIC** to any medications: No____ Yes____ Please list__________________________________

____

____

Do you use **TOBACCO** products: No ___Yes___ DAILY Amount _____________________________________

Do you drink **ALCOHOLIC** beverages: No ___Yes___ DAILY Amount ______________________________

I certify that the above information is correct and best of my knowledge.

Signature____ Date_____/_____/_____

Other Insurance Inquiry

Patient: ________________________________

Are **you** covered by another health plan besides ______________________________________
Primary Insurance Name

Yes No

If yes, you will need to provide our office with a copy of your card.

Name of Insurance Company: ____

Address: ____

Name of insured person: __________________________ Date of Birth: __________________

Policy Number: _________________________________ Effective Date: __________________

Termination Date: _____________________________ (if applicable)

______________________________________ ______________________
Patient Signature Date

Encuesta de Otro Seguro Medico

Tiene **usted** otro plan de seguro medico aparte de ______________________________________
Nombre de aseguranza que es primaria

Si No

Si contesto "Si", usted tiene que proporcionar nuestra oficina con una copia de la tarjeta.

Nombre del seguro medico ____

Direccion____

Nombre de la persona asegurada ________________________ Fecha de nacimiento ___________

Numero de póliza___________________________________ Fecha de empiezo ______________

Fecha de terminación_________________________________ (Si es aplicable)

______________________________________ ______________________
Firma del Paciente Fecha

Illness/ Injury Details
Detalles de Enfermedad/ Accidente

Please answer the following questions:

Is treatment today for an accident related injury: ☐ Yes ☐ No

1. WHEN did the illness or injury occur? ____
2. WHERE did the illness or injury occur? ____
3. HOW did the illness or injury occur? ____
4. Do you believe that your illness or injury was work related? ☐ Yes ☐ No
   If this is work related, did you report the condition to anyone?
   ☐ Yes ☐ No
   If yes, to whom? ___________________________________ Date: __________________
5. Do you expect to receive or have you been provided with Workers Compensation Benefits?
   Yes ☐ No ☐

(Note: Worker's Compensation is not the same of State Disability)

IF THIS VISIT IS RELATED TO AN INJURY CAUSED AT WORK, YOU WILL BE RESPONSIBLE FOR THIS BILL, IF IT HAS NOT BEEN APPROVED BY YOUR CLAIM ADJUSTOR.

Por favor responda a las siguientes preguntas:

¿Su consulta de hoy, está relacionada a un accidente? ☐ Si ☐ No

1. ¿CUANDO ocurrió la enfermedad o accidente?____
2. ¿DONDE ocurrió la enfermedad o accidente? ____
3. ¿COMO ocurrió la enfermedad o accidente? ____
4. ¿Usted cree que su enfermedad o accidente está relacionado con el trabajo?
   ☐ Si ☐ No
   ¿Si está relacionada con su trabajo, usted le reporto su condición a alguien?
   ☐ Si ☐ No
   ¿A quién se lo reporto? _________________________________ Fecha ________________
5. ¿Usted espera recibir o ha recibido beneficios de compensación del trabajador?

(Nota: Compensación del trabajador no es igual que la Incapacidad Estatal)

SI SU VISITA HOY ESTA RELACIONADO CON UN ACCIDENTE DE TRABAJO, USTED SERA RESPONSIBLE POR LA VISITA DE HOY AL MENOS QUE SU AJUSTADOR APROBO LA VISITA

____ ______________________________________

Patient Name (Nombre de paciente) Patient Signature (Firma del paciente)

____ ______________________________________

Insured Name (Nombre de miembro) Date (Fecha)