PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Legal Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Consent to Text? ☐ Yes ☐ No Email: _____

Height: _____ Weight: _____ Shoe Size: _____ Width ☐ M ☐ W ☐ XW

EMERGENCY CONTACT

Full Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

DEMOGRAPHICS

Race: ☐ Asian ☐ Asian Indian ☐ Black ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____
☐ I choose not to answer

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish
☐ Latin American/Latin, Latino ☐ Mexican ☐ Not Hispanic or Latino
☐ Puerto Rican ☐ South American ☐ Spaniard ☐ I choose not to answer

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widowed ☐ Partnered

Sexual Orientation: ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual
☐ Something else: _____ ☐ I choose not to answer

Gender Identity: ☐ Male ☐ Female ☐ Gender non-conforming
☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Other: _____ ☐ I choose not to answer

Assigned Sex at Birth: ☐ Male ☐ Female ☐ I choose not to answer

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

EMPLOYMENT

Employer Name: _____ Occupation: _____

Employer Phone: _____

FOOTDRx

PHARMACY INFORMATION:

All prescriptions must be sent electronically. If you do not have a preferred pharmacy, your prescription will be sent to our default pharmacy which is Capsule Pharmacy.

Pharmacy Name: _____

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

Pharmacy Phone #: _____ Fax#: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

INSURANCE / RESPONSIBLE PARTY INFORMATION:

Primary Insurance Name: _____

Member ID #: _____ Group #: _____

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Life Partner ☐ Other: _____

Primary Policyholder's Full Name: _____ DOB: _____

Is Policyholder's address different than patient's? ☐ Yes ☐ No

If yes:_____

Secondary Insurance Name: _____

Member ID #: _____ Group #: _____

PRIMARY CARE PHYSICIAN:

(Required for ALL Medicare Plans / Medicare HMO Plans / HMO Referral Plans)

Primary Care Physician (PCP) Name: _____

PCP Address: _____ Suite/Rm/ FL: _____

City: _____ State: _____ Zip Code: _____

PCP Phone: _____ PCP Fax: _____

Approximate Date of Last Appointment with PCP: _____

ALLERGIES (Check all that apply)

Adhesive/Tape		Demerol		Novocain	
Anticoagulant Therapy		Iodine		Penicillin	
Aspirin		Latex		Seafood	
Codeine		Local Anesthetics		Sulfa	

☐ No Allergies

☐ Other: _____

_____

FOOTDRx

REASON FOR TODAY'S VISIT: L = Left R = Right

Current Symptom	L	R	Current Symptom	L	R	Current Symptom	L	R
Ankle Injury			Flat Feet			Metatarsal Fracture		
Ankle Pain			Foot or Leg Cramps			Neuroma		
Ankle Sprain			Foot Injury			Plantar Warts		
Athlete's Foot			Foot Pain			Plantar Fasciitis		
Blister on Foot/Toe			Foot Sprain			Stress Fracture		
Broken Toe			Glass			Swelling in Ankles / Feet		
Broken Nail			Ganglion			Tendon Strain		
Burn			Gangrene			Tired Feet		
Bunion			Gout			Toe Fracture		
Chronic Ankle			Hammer Toes			Toenail Fungus		
Corns / Calluses			Heel Pain					
Diabetic			Ingrown Toenails					

Other: _____

MEDICAL HISTORY: Please indicate if you have or had any of the following:(Check all that apply)

AIDS/HIV		Edema		Organ Transplant	
Anemia		Fibromyalgia		Osteoporosis	
Angina		Foot Deformity		Pacemaker	
Arthritis		Frost Bite		Peripheral Vascular Disease	
Artificial Joints		Gout		Poliomyelitis	
Asthma		Headaches		Pulmonary Embolism	
Back Pain		Heart Disease		Raynaud's Disease	
Bleeding Disorders		Hepatitis		Rheumatoid Arthritis	
Blood Clot		Hernia		Seizures/Epilepsy	
Cancer		High Blood Pressure		Stroke	
Coronary Artery Disease		Hypertension		Substance Abuse	
Deep Vein Thrombosis		Kidney Disease		Thyroid Problems	
Diabetes		Leg or Foot Ulcers		Tuberculosis	
Dialysis		Liver Disease		Varicose Veins	
Dyslipidemia		Lung Disease			

Other:_____

SURGERIES/ HOSPITALIZATIONS:

_____

_____

SUBSTANCE USE:

Tobacco Use: ☐ Never ☐ Former Smoker ☐ Current Smoker (daily) ☐ Current Smoker (some days)

Use of other forms of tobacco/nicotine: ☐ Yes ☐ No

Level of Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Use of any illicit or recreational drugs: ☐ Yes ☐ No

Level of Caffeine Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

PHYSICAL ACTIVITY / EXERCISES

Please list all physical activities/exercises you participate in and how often these activities are performed: _____

_____

CONSENT TO CALL

Our office offers automated phone calls to your mobile phone for specific features such as appointment reminders, test results, and more. Please check one of the following options:

☐ Yes, I want to receive automated calls from the practice.

☐ No, I do not want to receive automated calls from the practice.

PRACTICE CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature of Beneficiary, Guardian, or Personal Representative

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Please print name of Beneficiary, Guardian, or Personal Representative

_____ _____

Date Relationship to Beneficiary