

Adult Patient Registration Forms

Today's Date: _____

Last Name: _____

Home Phone: _____

First Name: _____

Cell Phone: _____

Address: _____

Date of Birth: ____/____/____ Age ____

City: _____ State _____ Zip _____

SSN: _____

Email Address: _____

Employer: _____ City: _____ Phone: _____

Marital Status: Single Married Divorced Separated Widowed

Gender: Female Male Deferred

Race: African Amer/Black Caucasian/White Deferred
Amer Indian/Alaska Native Hispanic/Latino
Native Hawaiian/Pac Islander Other

Ethnicity: Hispanic, Latino, or Spanish Origin
Not Hispanic, Latino, or Spanish Origin

Name of Guardian or POA:

Emergency Contact : _____ **Phone:** _____ **Relationship:** _____

INSURANCE INFORMATION (Please give receptionist a copy of your card and Complete)

Primary Insurance: _____ Secondary Insurance: _____
Cardholder: _____ Cardholder: _____
ID No. _____ Group No. _____ ID No. _____ Group No. _____
Relationship to Patient: _____ Relationship to Patient: _____
Date of Birth: ____/____/____ Date of Birth: ____/____/____
Social Security Number: _____ - _____ - _____ Social Security Number: _____ - _____ - _____

MEDICAL RELEASE INFORMATION

Who may we release medical information to?

- 1. _____ Phone: _____ Relationship: _____
- 2. _____ Phone: _____ Relationship: _____

May we leave medical information on the answering machine or voice mail of the phone number(s) you have listed? **Yes No**

Patient Name: _____

REFERRING SECTION (Circle one) PRIMARY CARE PHYSICIAN

Family Member _____

Name: _____

Doctor _____

Attorney _____

City: _____

Other _____

Phone: _____

PATIENT'S PAST MEDICAL HISTORY (Please check all that apply) NO PAST MEDICAL HISTORY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis, Jaundice | <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Deafness or hearing trouble | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Depression | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Poly/Fibromyalgia |
| <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Diabetes <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis/Osteoarthritis | <input type="checkbox"/> Emphysema or COPD | <input type="checkbox"/> <i>Dialysis</i> <input type="checkbox"/> <i>No Dialysis</i> | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Fainting/loss of consciousness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Fatigue/Weakness | <input type="checkbox"/> Lumbar Disk Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Blood Clots/DVT | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Skin Problems/Disorders |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Morning Stiffness | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bone/Joint Infection | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Thyroid High Low |
| <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation | <input type="checkbox"/> Heart Condition (congenital) | <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> TMJ (Jaw locks or pops) |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Numb/Tingling hands/feet | <input type="checkbox"/> Ulcers/Reflux/GERD |
| <input type="checkbox"/> Carpal Tunnel, Neuropathy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vascular/Circulatory |
| <input type="checkbox"/> Chest Pain, Angina | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Other _____ | | | |

I have reviewed this Information, and by my signature, attest that the answers are true and accurate to the best of my ability:

Patient Signature

Date:

Guardian Signature

Date

Podiatric and Medical History

Name _____

Weight _____ Height _____ Shoe Size _____ Shoe Style (Boot, Heel, Athletic, Casual, Dress, Sandals, flip-flops, backless)

Chief Complaint: (What brings you into the office today? Please provide detailed information)

Location: (Where is your pain?) _____

Please indicate the **severity** of the pain or discomfort. (Circle) None Mild Moderate Strong Severe

When did this initially **start**? _____ Days Weeks Months Years **AGO**

How would you **describe** the discomfort? (Circle those that apply)

Sharp Shooting Throbbing Tingling Numb Burning Itching Aching Tender Dull

Have you had any treatment done for this condition? YES NO

If yes, what kind? _____

What **aggravates** the condition? (Circle all that apply) Shoes Walking No Walking Activities

Other _____

Have you ever been treated for any of the following: (please **circle** those that apply)

Corns/Calluses Warts Rash Leg or Foot Ulcers Fungus Nails Athlete's Foot Broken foot bones Neuroma Ingrown Nails
Hammertoes Broken Ankle Foot numbness Cramps in legs/feet Bunions Ankle sprain Lower Back Pain Arch Pain
Gait (walking) problems Knee Pain Childhood Problems In-toeing Toe Walking Flat Feet High Arches
Other: _____

Did you previously or do you now wear?:

Shoe Insoles? _____ If yes, are you still using them? _____ Did they help? _____

Orthotics? _____ If yes, are you still using them? _____ Did they help? _____

Percent of waking hours spent on your feet? 10% 20% 40% 60% 80% 100%

List the sports or activities you are involved in: (Walking, Running, Weights, Cycling, Pilates, Aerobics, Curves, Treadmill)

Social History:

Do you **smoke now**? Yes or No If yes how many packs a day? _____ For how many years? _____

Did you ever **smoke**? Yes or No If yes how many packs a day? _____ For how many years? _____

If you quit, when did you do so? _____

Alcoholic beverages? (Circle) None Rarely Moderately Daily (# per day _____) Quit

Recreational Drugs? (Circle) None Rarely Moderately Daily Quit

Name _____

Surgical Procedures (You Have Had Performed and approx Date performed):

Hospitalizations (Other than for Surgeries): _____

Medications: (please provide a list to the receptionist if needed)

NAME	Reason for taking	Dose

Pharmacy: _____ **Location:** _____ **Phone:** _____

Allergies:	YES	NO		YES	NO
Penicillin	_____	_____	Latex	_____	_____
Morphine	_____	_____	Codeine	_____	_____
Novocaine	_____	_____	Other Anesthetics	_____	_____
Aspirin	_____	_____	Advil, Aleve, Motrin	_____	_____
Sulfa Drugs	_____	_____	Adhesive Tape	_____	_____
Shrimp, Iodine, Merthiolate	_____	_____			

Others: _____

CONSENT TO TREATMENT

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

Patient Signature _____ **Date** _____

Guardian Signature _____ **Date** _____