PATIENT REGISTRATION FORM

(FIRST SECTION refers to the PERSON WHO IS RESPONSIBLE FOR THE BILL)

Relationship to patient: Self (skip to next section) Parent Spouse Other_______________

BILLING INFORMATION

First Name: ________________________ M_____ **Last Name:** ________________________________

Address: ____

City: ________________________ **State:** _______ **Zip:** ________________

Home Phone: _______________________ **Cell Phone:** ________________

Social Security No: ________-________-________ **Date of Birth:** ______ -______ - ______

Employer Information: **Name:** ____

Address: ____ **Phone:** __________________________________

PATIENT INFORMATION ONLY

First Name: _____________________M___ **Last Name:** _____________________ **SEX: Male Female**

Address: ____

City: ______________________ **State:** _______ **Zip:** _________ **Email**_______________________________

Home Phone: _______________________ **Cell Phone:** ____________________

Birth Date: Month _________ **Day** ____ **Year** ______ **Social Security No:** _______-_______-_______

Marital Status: (circle one) Single Married Divorced Widowed Separated

Family Dr. ________________________ **Pharmacy:** __________________ **SHOE SIZE:** _______________

Emergency Contact: _____________________ **Phone:** _______________ **Relationship:** ___________________

PATIENT: EMPLOYMENT INOFRMATION MUST BE COMPLETED:

Circle One: Full Time Part Time Self –Employed Unemployed Disability College Student

Employer Name: ____

Address: ____ **Work Phone No.** _____________________

PREMIER PODIATRY GROUP
PATIENT'S HEALTH HISTORY SHEET

PATIENT NAME: ____

DATE OF BIRTH: ___________________________________

REASON FOR VISIT: ____

PREVIOUS XRAYS/ MRI'S of FEET OR ANKLES: YES / NO   WHEN & WHERE:__________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

MEDICATIONS TAKEN DAILY: ____

ALLERGIES TO MEDICATION & TYPE OF REACTION: ____

PAST MEDICAL HISTORY: ____

PAST SURGERIES: ____

TOBACCO USE: SMOKE (AND) OR CHEW: YES NO PAST

ALCOHOL USE: YES HOW OFTEN______________________ **NO PAST**

PLEASE CIRCLE YES OR NO **IF YOU HAVE ANY OF THE FOLLOWING:**

Condition		
AIDS/HIV	YES	NO
ANEMIA	YES	NO
ARTHRITIS	YES	NO
ARTIFICIAL HEART VALVE	YES	NO
ARTIFICIAL JOINT	YES	NO
ASTHMA	YES	NO
BACK PROBLEMS	YES	NO
BLEEDING DISORDER	YES	NO
CANCER TYPE__________	YES	NO
CHEST PAINS	YES	NO
CHRONIC DIARRHEA	YES	NO
CIRCULATORY DISORDER	YES	NO
DIABETES	YES	NO
EAR PROBLEMS	YES	NO
EPILEPSY	YES	NO
EYE PROBLEMS	YES	NO
FAINTING	YES	NO
HEPATITIS TYPE______	YES	NO
FOOT OR LEG CRAMPS	YES	NO
GOUT	YES	NO
HEADACHES	YES	NO
HEART DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
LIVER DISEASE	YES	NO
NEUROPATHY	YES	NO
PSYCHIATRIC CARE	YES	NO
RASH	YES	NO
RESPIRATORY DISEASE	YES	NO
SHORTNESS OF BREATH	YES	NO
SINUS PROBLEMS	YES	NO
STOMACH ULCERS	YES	NO
STROKE	YES	NO
SEXUALLY TRANSMITTED DZ.	YES	NO
SWELLING IN ANKLES	YES	NO
TUBERCULOSIS	YES	NO
ULCERS ON LEGS/FEET	YES	NO
UNEXPLAINED WEIGHT LOSS	YES	NO
VARICOSE VEINS	YES	NO

OTHER________________________________

DATE:________________________________