



Date of Appointment: _____

Patient Registration Form

Patient Information

Patient's First Name		Middle Name	Last Name <small>(as it appears on insurance card or ID)</small>		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City	State	Zip	
Consent to text		Mobile Phone			
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School			Employer/School Phone		
		City	State	Zip	

Emergency Contact Information

		Relation to Patient
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Billing and Insurance

Primary Health Insurance

Plan Number	Group Number	Insured's Employer/School			
		Relation to Patient	Insured's Phone Number		
		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number		
Insured's Name <small>(as it appears on insurance card or ID)</small>		Relation to Patient	Insured's Phone Number		

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit : Describe your foot/ankle issue(s)

Please describe any previous treatment and care you have received for this problem.

Pain Assessment

Indicate your level of pain on a scale of 1 - 10.
(10 = worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

Check the symptoms that best describe your problem.

Stiffness Pain Instability Swelling
 Numbness Other: _____

Are your symptoms getting...

Better Gradually Better Rapidly
 Worse Gradually Worse Rapidly

What **improves** your symptoms?

Rest _____ _____
 Other: _____

What makes your symptoms **worse**?

Activity Cold
 Other: _____

Podiatry

Do you have any of the following?

Ankle Sprain Enlarged Veins Knee Pain
 Arch Pain Flat Feet Leg Ulcers
 Athlete's Foot Foot Numbness Loss of Sensation in Feet
 Broken Ankle Foot Ulcers Lower Back Pain
 Broken Foot Bones Fungal Nails Rash on Feet
 Bunions High Arch Feet Swelling in Ankles
 Burning in Feet Heel Pain Swelling in Feet
 Corns / Calluses Hammer Toes Swelling in Legs
 Cramps in Feet Ingrown Nails Tingling in Feet
 Cramps in Legs In-toeing

Do you currently or have you ever worn orthotics?

Yes No

Does your foot pain limit your desired activity?

Yes No

Are your first steps out of bed in the morning painful?

Yes No

Have you ever had any other foot problems?

Yes No

If so, please describe: _____

Lifestyle Factors

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs?

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week 3

How many hours a day do you stand?

of hours _____

What type of shoes do you wear?

Flat Heels Boots Loafers Oxfords
 Sandals Sneakers Other: _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Current Medications

Are you currently taking any blood thinners?

Yes No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

Adhesive Tape Antibiotics Latex
 Barbiturates (Sleeping Pills) Aspirin Iodine
 Codeine Sulfa Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Past Medical History

Have you ever had any of the following?

- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | |

Family History

Has anyone in your family ever had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |

Details: _____

Women Only

Are you pregnant?

- Yes No

Are you breastfeeding?

- Yes No

Patient's Authorization and Assignment of Benefits: I hereby authorize the processing of my medical insurance either by electronic or manual method by AFAAC. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards and payment card to the office to pay for services rendered to AFAAC. I certify that the information I have reported with regard to my insurance and payment method is correct. I further authorize the release of any necessary information, including medical information, for this or any related claims. I grant permission to contact me via email/text as allowed by the FCC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, by me, at any time, in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of responsible party: _____ Date: _____

Other Notes:

