AUSTIN
FOOT & ANKLE CENTER

Date of Appointment: ____________________

Patient Registration Form

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	email		
Patient's Address			City	State	Zip
Conset to text		Mobile Phone			
Referred by		Primary Care Physician			
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School		Employer/School Phone		
		City	State	Zip

Emergency Contact Information

		Relation to Patient

What is the reason for your consultation

What is your shoe size:

Weight:

Height:

____________________ Signature of Patient or Authorized Guardian

____________________ Date

Date of Appointment: ______

Name ______ Gender ______ Age ______

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

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 ______

Date of Appointment: ____________

Name ____________ Gender ______ Age ______

Past Medical History

Have you ever had any of the following?

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

Family History

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

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

Details:

____

____

Women Only

Are you pregnant?

- [ ] Yes
- [ ] No

Are you breastfeeding?

- [ ] Yes
- [ ] No

Other Notes:

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____

Patient's Authorization and Assignment of Benefits:

AFAAC = Austin Foot & Ankle Center ; Insurance Provider = Company

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 & payment cards to the office to pay for services rendered to AFAAC. I certify that the information I have reported with regard to my insurance coverage 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.

Austin Foot & Ankle Center ("Clinic") is a participating provider with my insurance ("Company")

I am covered by one of the Company health insurance plans.

The health plan under which I am covered includes benefits for some or all of the services provided by the Clinic

Despite the above, i do wish Clinic to submit a claim to Company for services provided to me by Clinic, for some or all services or durable medical equipment provided.

Until such time as I may otherwise advise Clinic in writing, I elect to pay for all services I receive from Clinic at their provided rates.

By election to self-pay for services, any payments I make to Clinic will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with Company unless otherwise permitted under the terms of my health plan.

I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

I have freely chosen to self-pay for services after having asked Clinic about payment options and having carefully considered those options

Date: ____

Name: ____

Signature: ____