Patient Registration

Please Print

Last Name:_____

First Name:_____

Middle Name:_____

Sex:_____Date of Birth:_____

Social Security No:_____

Address:_____

Zip:_____

City:_____State:_____

Home Phone:_(_____)_____

Work Phone:_(_____)_____

Mobile Phone:_(_____)_____

Email Address:_____

Marital Status:_____

Guarantor Information (to whom statements are sent)

Last Name:_____

First Name:_____

Middle Name:_____

Other:

How did you hear about us?_____

Patient's Primary Care Physician (PCP):_____

Nearest Relative in Case of an Emergency

Name:_____ Relationship:_____

Address:_____ Contact Number:_____

Primary Insurance Information

Insurance Plan Name:_____

ID Certification Number:_____

Secondary Insurance Information

Insurance Plan Name:_____

ID Certification Number:_____

Patient Intake Information

ENDOCRINOLOGIST / DIABETES SPECIALIST:_____or NOT APPLICABLE (circle)

DATE LAST SEEN:_____or NOT APPLICABLE (circle)

BRIEFLY DESCRIBE YOUR FOOT PROBLEM:_____

HOW LONG HAS IT BEEN BOTHERING YOU?_____

DO YOU SMOKE?_____YES_____NO PREVSIOUSLY SMOKED?_____YES_____NO

DO YOU USE SMOKELESS TOBACCO?_____YES_____NO

MAY WE CONTACT YOUR PRIMARY PHYSICIAN ABOUT YOUR HEALTH?_____YES_____NO

WHAT IS YOUR SHOE SIZE?_____

DO YOU HAVE ANY ALLERGIES?_____YES_____NO

IF YES, PLEASE DESCRIBE:_____

WHAT PHARMACY DO YOU GO TO?_____

YOUR PHARMACY'S ADDRESS_____

ASSIGNMENT AND RELEASE: I hereby authorize payments directly to the physician for medical and/or surgical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company. I also understand that if my insurance requires a referral, I will obtain one, or I will be billed in full for my visit. I hereby authorize the release of information for insurance claim purposes. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I consent to foot/ankle photographs and x-ray imaging which may become part of my permanent records and/or sent to other physicians and insurance companies as may be needed for my care. I am aware that this practice has a no-show/late cancellation policy in place, and I may be charged $50 if I do not give a 24-hour cancellation notice. This consent applies to today's visit and all future visits with this practice. I understand all of the above and hereby state that the information I have provided is correct to the best of my knowledge.

Signed:_____Date:_____