

# West Coast Foot and Ankle

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Today's Date:		Primary Care Physician Name and Number:			
Primary Language:		Race/Ethnicity: (optional)			
Patient's Last Name, First, Middle:			Marital status: Single Mar Div Sep Wid		
Is this your legal name? Yes No	If not, what is your legal name?	Social Security No.:	Birth date: ( ) -	Age:	Sex: (CIRCLE ONE) M F
Street Address:			Home phone No.: ( ) -	Work phone No.: ( ) -	
City:		State:	Zip code:	Cell phone No.: ( ) -	
* May we leave Medical Information on your Voice Mail? YES NO (CIRCLE ONE)					
E-mail Address: @					
Employer:			Address:		
I was referred to Podiatrist by: (CHECK ALL THAT APPLY)			Dr. _____	Insurance Plan	Hospital
Family	Friend	Internet	Yellow Pages	Worker's Comp.	

INSURANCE INFORMATION					
(PLEASE GIVE YOUR INSURANCE CARD AND A PICTURE I.D. TO THE RECEPTIONIST.)					
Is this patient covered by insurance? YES NO (CIRCLE ONE)					
Name of <u>Primary</u> Insurance:		Policy No.:		Specialist Co-Payment: \$	
Patient's relationship to subscriber: CHILD SELF SPOUSE OTHER (CIRCLE ONE)					
Name of <u>Secondary</u> Insurance: (If applicable)		Subscriber's name:		Policy No.:	
Patient's relationship to subscriber: CHILD SELF SPOUSE OTHER (CIRCLE ONE)					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

NOTICE OF PRIVACY PRACTICES	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize West Coast Foot and Ankle or insurance company to release any information required to process my claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice.</p>	
Patient's/ Guardian's Signature _____	Today's Date: _____

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# West Coast Foot and Ankle

## Medical History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is the reason for today's visit?

\_\_\_\_\_

Shoe size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Do you:      Smoke? YES / NO      Packs per day \_\_\_\_\_      # Years smoked \_\_\_\_\_  
                 Drink Alcohol? YES / NO      Drinks per Day: \_\_\_\_\_      Per Week: \_\_\_\_\_  
                 Drink cola/coffee? YES / NO      How much per day? \_\_\_\_\_

List the **medications** you are **now** taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any **allergies** you have to **drugs, food or other items**:

\_\_\_\_\_

Women **ONLY**:

Are you pregnant? \_\_\_\_\_

List **All** Operations:

\_\_\_\_\_  
\_\_\_\_\_

Please Check if **any relative** ( parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood Pressure: _____	Kidney Disease: _____	Asthma: _____	Stroke: _____
Bleeding Tendencies: _____	Tuberculosis: _____	Cancer: _____	Seizures: _____
Colitis: _____	Gout: _____	Ulcers: _____	Emphysema: _____
Heart Disease: _____	Diabetes: _____	Strokes: _____	Mental Illness: _____
HIV/ STD's _____	<b>Other illnesses:</b> _____		

Have **YOU** had any of the follow illnesses: (PLEASE CIRCLE)

Diabetes	Kidney Disease	Asthma	Cancer type: _____
Seizures	Heart Disease	Glaucoma	Eczema
Ulcer	Tuberculosis	Heart Attack	Arthritis type: _____
Phlebitis	Cholesterol	Hepatitis type: _____	Poliomyelitis
Bronchitis	Thyroid Disease	Venereal Disease	Heart Murmur
High/low Blood Pressure		Rheumatic Fever	Poor Circulation
HIV/AIDS	STDs	Stroke	
<b>Other Illnesses:</b> _____			

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications. I certify that the information above is true and correct to the best of my knowledge. I give permission to Dr. Augustus/ Dr. Bell and/or Dr. Leaming to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

\_\_\_\_\_  
Patient's/Guardian's Signature

\_\_\_\_\_  
Today's Date