West Coast Foot and Ankle

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Today's Date:			**Primary Care Physician** Name and Phone Number:		
Primary Language:			**E-mail Address:** @		
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.:** **( ) -**		

(Optional) **Race** American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐
Native Hawaiian or Pacific Islander ☐ White ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Employer:			**Address:**	
I was referred 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 :	**Relationship to patient:**	**Home phone no.:** **( )**	**Cell phone no.:** **( )**

NOTICE OF PRIVACY PRACTICES

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.

_____ _____

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?

_____

May we leave Medical Information on your voice mail? YES NO (Circle one)

Height:_____ Weight:_____ Shoe size:_____ Age:_____

Women **Only :** Are you pregnant?**:** _____

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

_____ _____ _____

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

_____ _____ _____
_____ _____ _____
_____ _____ _____

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

Arthritis ☐ Type:_____	Glaucoma ☐	Kidney Disease ☐	STDs ☐
Asthma ☐	Heart Attack ☐	Low Blood Pressure ☐	Stroke ☐
Bronchitis ☐	Heart Disease ☐	Phlebitis ☐	Thyroid Disease ☐
Cancer ☐Type:_____	Heart Murmur ☐	Poliomyelitis ☐	Tuberculosis ☐
Cholesterol ☐	Hepatitis ☐Type:____	Poor Circulation ☐	Ulcer ☐
Diabetes ☐ Type:_____	High Blood Pressure ☐	Rheumatic Fever ☐	Venereal Disease ☐
Eczema ☐	HIV/AIDS ☐	Seizures ☐	

Other Illnesses:_____

List **All** Operations:

_____ _____ _____
_____ _____ _____

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

Asthma ☐	Diabetes ☐	High Blood Pressure ☐	Seizures ☐
Bleeding Tendencies ☐	Emphysema ☐	HIV/ STDs ☐	Strokes ☐
Cancer ☐	Gout ☐	Kidney Disease ☐	Tuberculosis ☐
Colitis ☐	Heart Disease ☐	Mental Illness ☐	Ulcers ☐

Other illnesses: _____

Do you:	**Drink Alcohol?**	**YES / NO**	**Drinks per Day:_____ Per Week: _____**
	Drink cola/coffee?	**YES / NO**	**How much per day?_____**
	Smoke?	**YES / NO**	**Packs per day_____ # Years smoked_____**

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 / Dr. Leaming and/or Dr. Recalde 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**