

Acct # \_\_\_\_\_

Date \_\_\_\_\_

**PATIENT REGISTRATION FORM-PLEASE USE BLACK INK**

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Patient's Birthdate \_\_\_\_\_  
First M Last SS# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ S M D W Marital Status-Circle One  
First M Last

Responsible Party/Parent(if child) \_\_\_\_\_  
First M Last Relationship

Patient's Address \_\_\_\_\_  
Number & Street (If PO Box, include street address) City State Zipcode

Home Phone(\_\_\_\_) Cellular Phone(\_\_\_\_) E-Mail Address \_\_\_\_\_

Patient's Employer (if child, father's) \_\_\_\_\_ Employer's Phone (\_\_\_\_) \_\_\_\_\_

Patient's Insurance (if child, father's) \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's Employer (if child, mother's) \_\_\_\_\_ Employer's Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Insurance (if child, mother's) \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Emergency Name/Phone/Relationship \_\_\_\_\_  
*This should be someone outside of your home, if possible*

Family Dr. \_\_\_\_\_ Y N  
First M Last City State Did he/she refer you?

Referred By \_\_\_\_\_  
First M Last City State Relationship

How Did You Find Out About Us? \_\_\_\_\_ Another Patient \_\_\_\_\_ Phonebook \_\_\_\_\_ Sign \_\_\_\_\_ Radio \_\_\_\_\_ Website [footankleldr.com](http://footankleldr.com)

**Family Medical History**

Has anyone in your immediate family ever had: Diabetes; Heart Disease; High Blood Pressure; Stroke; Bleeding Disorder; Cancer; Depression  
\_\_\_\_\_ NO \_\_\_\_\_ YES, please list details below.

Relationship	Disease/Ailment
Father	_____
Mother	_____
Siblings	_____

**Personal Medical History**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_ Smoke \_\_\_\_\_ pkgs per day Alcohol \_\_\_\_\_ oz per day

Previous Hospitalizations/Surgeries \_\_\_\_\_ None Females: Are you pregnant at this time? \_\_\_\_\_ NO \_\_\_\_\_ YES

**ALLERGIES:** Please check those that apply to you and list type of reaction

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> NO KNOWN ALLERGIES | <input type="checkbox"/> Cortisone       | <input type="checkbox"/> Latex            | <input type="checkbox"/> Sulfa                          |
| <input type="checkbox"/> Adhesive Tape      | <input type="checkbox"/> Demerol         | <input type="checkbox"/> Local Anesthesia | <input type="checkbox"/> Topicals, ie lotions or creams |
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Iodine Dye      | <input type="checkbox"/> Novacaine        | <input type="checkbox"/> Other                          |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Iodine, Topical | <input type="checkbox"/> Penicillin       | _____   |

Describe reactions: \_\_\_\_\_

For Office Use Only: Date: \_\_\_\_\_ B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Initials \_\_\_\_\_

Shoes (initial pair): \_\_\_\_\_ PadNet (Initial) \_\_\_\_\_