PATIENT REGISTRATION FORM

Patient's name: _____ Preferred Name: _____Today's Date: _____

Date of Birth: _____ Age: _____ SS# _____ Gender: Male / Female

Mailing Address: _____

City/State/Zip: _____ Apt/Condo# _____

Street Address (If different) _____

E-Mail: _____ ☐ Yes, please activate a patient portal account using this email address

Home #: _____ Cell #: _____ Work #: _____

Employer _____ Occupation _____

Hand Dominance: ☐RT ☐ LT Preferred Language: ☐ English ☐ Other: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other Race

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Communication Preference: ☐ Home Phone ☐ Cell Phone ☐ Mail ☐ E-Mail

Primary Care Physician: _____We will be sending copies of any treatment we provide

Spouse Information: Name _____ Date of Birth_____

Address (if different) _____ City/State/Zip _____

Employer_____ Work # _____ Ext _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Contact methods agreement**: By signing the authorization agreement on the next page, you agree, in order for us to service this account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. ***Please initial: _____

Insurance Information

Primary: _____

Secondary: _____

IS THIS A WORK INJURY? ☐ Yes ☐ No
IF SO, DID YOU FILE A CLAIM? ☐ Ye s ☐ No
IS THIS AN AUTO INJURY? ☐ Yes ☐ No
IF SO, DID YOU FILE A CLAIM? ☐ Yes ☐ No

Continued on back side

Authorization Agreements (For all patients to complete)

I authorize my medical treatment, billing information and appointment times to be discussed without limitation with the person/people listed below.

Name: _____ Relation:_____ Ok to leave message? ☐ Yes ☐ No
Name: _____ Relation:_____ Ok to leave message? ☐ Yes ☐ No
Name: _____ Relation:_____ Ok to leave message? ☐ Yes ☐ No
Name: _____ Relation:_____ Ok to leave message? ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF **NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I received a copy of this office's Notice of Privacy Practices Form, or that one was offered to me.

Patient / Guardian Signature: _____Date: ____/____/____
(If patient is a minor, please have a parent sign)

Authorization Agreement: I request that payment of authorized health insurance benefits be made on my behalf to West Bay Foot and Ankle, P.L.L.C. for any services furnished me. I *understand and agree* that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. In order to determine benefits, I authorize the doctor or his mid-level provider to release all medical information, including my full medical history, surgical history & HIV status (if requested) to the insurance company(ies) being billed. I also understand that I will be charged a $35.00 processing fee for any check I write that is returned due to non-sufficient funds. This signature further shows my consent to the contact methods agreement on page one of this form and that I have reviewed or was offered the financial policy.

_____ ____/____/_____
Patient or responsible party signature Date

FOR ALL PEDIATRIC PATIENTS & YOUNG ADULTS (up to age 26)

Parent's Information

Mother's Information
Name _____ Date of Birth_____/_____/_____ SS# _____

Home Address_____City/State/Zip_____

Employer_____Address_____

Home Ph#_____ Mobile phone# _____ Work # _____ext.____

Father's Information
Name _____ Date of Birth_____/_____/_____ SS# _____

Home Address_____City/State/Zip_____

Employer_____Address_____

Home Ph# _____ Mobile phone# _____ Work # _____ext.____

With whom does patient reside? (Check all that apply) ☐ Mother ☐ Father ☐ Joint Custody ☐ Other
Who is the guarantor? (Person responsible for bills) ☐ Mother ☐ Father ☐ Self (age 18-26)
Who has legal custody of the child? ☐ Mother ☐ Father ☐ Joint Custody ☐ Other

Ankle/Foot History

Name: _____ **Date of birth:** _____ **Today's date:** _____

Where are you experiencing difficulty? ☐ Ankle ☐ Foot

Which side? ☐ Right ☐ Left ☐ Both: If both, which is worse? ☐ Right ☐ Left

How long have you had difficulty? _____

What do you think may have caused your symptoms?

_____

_____

If it was an injury, when did it happen? _____

Is this a work related injury? ☐ No ☐ Yes; have you filed a claim ☐ No ☐ Yes ☐ N/A

Is this an auto related injury? ☐ No ☐ Yes; have you filed a claim ☐ No ☐ Yes ☐ N/A

Which of the following symptoms are you experiencing?

____ Pain ____ Popping ____Stiffness ____Tearing ____Weakness ____Grinding ____Swelling

____Numbness / Tingling ____Instability / Slipping sensation ____Locking / Catching

Where do you experience the majority of your discomfort? Is it generalized or in a specific area?

_____

Does your pain radiate? ☐ Yes ☐ No

If yes, where does it radiate to? _____

Do you have night pain? ☐ Yes ☐ No

Do changes in the weather make your pain worse? ☐ Yes ☐ No

Please describe the discomfort you are having: ☐ Aching ☐ Constant ☐ Sharp ☐ Intermittent

☐ Burning ☐ Present only with certain activities

Please mark with an "X" the severity of your discomfort on a scale of 1 to 10 below

(1=minimal, 10=extremely severe) |----|----|----|----|----|----|----|----|----|----|

1 5 10

How is your condition progressing? ☐ Getting better ☐ Getting worse ☐ Staying the same

Do you experience any discomfort with the following activities?

Lower extremity problems

☐ Going up stairs

☐ Squatting

☐ Sitting for a prolonged period of time

☐ Driving

Continued on back side

Patient Name: _____

Do any other specific activities give you discomfort?

_____

Does your condition interfere with any of the following?

☐ Daily activities ☐ School activities ☐ Work activities ☐ Recreation or sports activities

Please explain:

_____

Have you previously been evaluated for this condition by:

☐ Primary care physician ☐ Urgent care setting ☐ Another orthopedic surgeon ☐ Emergency room visit

Please check any treatments that you have tried for your condition.	Has the treatment helped?	
☐ Rest	☐ Yes	☐ No
☐ Ice	☐ Yes	☐ No
☐ Anti-inflammatory medication (which ones? _____)	☐ Yes	☐ No
☐ Pain medication	☐ Yes	☐ No
☐ Cortisone injection	☐ Yes	☐ No
☐ Immobilization	☐ Yes	☐ No
☐ Physical Therapy	☐ Yes	☐ No
☐ Other: _____	☐ Yes	☐ No
Have you had any other significant injury to this body part in the past?	☐ Yes	☐ No

If yes, please explain:

_____

If yes, did you recover fully? _____

Have you ever had surgery on this area in the past? ☐ Yes ☐ No

If yes, please explain: (date, doctor, procedure)

_____

Have you had any imaging studies for the injury that we are evaluating you for?

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ Arthrogram ☐ Other: _____

Please list any other information you feel would assist your doctor with your treatment:

_____

_____

Patient Signature: _____

Physician Signature: _____

Orthopedic History (page 1)

Name: _____ Date of Birth: _____ Today's date: _____

Chief Complaint

Why are you seeing the doctor today? _____

Briefly describe onset/cause of symptoms: _____

Current problem is the result of a(n): **check** all that apply Date of Injury _____

☐ Car accident ☐ Work accident ☐ Accident ☐ Other

How were you referred here? ☐ Primary Care Doctor ☐ Specialist ☐ Google ☐ Website ☐ Family / Friend
☐ WebMD online ☐ Vitals online ☐ Google Map Search ☐ phone book

If you were referred here by another doctor, please share their name here: _____

Who is your family doctor? _____ Phone # _____

Review of Systems

Are you currently having or have you had problems with the following (please indicate "yes" even if controlled with medication):

	Circle		Describe all Yes responses, please be specific
Eyes, Ears, Nose, Throat	☐No	☐Yes	_____
Lungs, Breathing Disorders, Asthma	☐No	☐Yes	_____
High Blood Pressure	☐No	☐Yes	_____
Heart Disease / CHF / MI	☐No	☐Yes	_____
Heart Murmur	☐No	☐Yes	_____
CVA / Stroke	☐No	☐Yes	_____
Numbness / Tingling/ Paralysis	☐No	☐Yes	_____
Neurological/Psychological Disorder	☐No	☐Yes	_____
Depression/Anxiety	☐No	☐Yes	_____
Bleeding Disorders	☐No	☐Yes	_____
Gastrointestinal Disorders	☐No	☐Yes	_____
Cancer	☐No	☐Yes	_____
Thyroid Disease	☐No	☐Yes	_____
Diabetes	☐No	☐Yes	_____
Arthritis / Osteoporosis	☐No	☐Yes	_____
Polio / TB / AIDS / Hepatitis	☐No	☐Yes	_____
Skin Disorders	☐No	☐Yes	_____
Bowel / Bladder Disorders	☐No	☐Yes	_____
Kidney Disease / Dialysis	☐No	☐Yes	_____
Sleep Apnea	☐No	☐Yes	_____
C-PAP	☐No	☐Yes	_____
History of MRSA	☐No	☐Yes	if yes, date of last nasal swab _____/_____/_____
Other – please explain	☐No	☐Yes	_____

Continued on back side

Name: _____ **Date of Birth:**_____ **History (page 2)**

Past Medical History: **Year:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Surgical History – List All (not just orthopedic): **Year:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had general anesthesia? ☐No ☐Yes
Have any problems with anesthesia? ☐No ☐Yes Describe: _____

Social History

☐ Work in the home ☐ Employed (occupation _____) ☐Student ☐Disabled ☐Retired

☐ Single ☐ Married ☐Divorced ☐Separate ☐Widowed

Children? ☐ No ☐ Yes # _____ Do you live alone? ☐ No ☐Yes

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐Rarely ☐Never

What type of exercise? _____

History of substance abuse? ☐ No ☐ Yes What? _____

Smoking Status:
☐Chews Tobacco
☐Current Occasional Tobacco Smoker ☐Former Tobacco Smoker ☐Never smoked Tobacco
☐Current Every Day Tobacco Smoker: please select a level…
☐Heavy (20-30 cigs/day) ☐Moderate (10-19 cigs/day) ☐Light (1-9 cigs/day) ☐Very Heavy (40+ cigs/day)
☐Vaping: ☐ current every day ☐ occasional
☐Marijuana: ☐ Recreational ☐ Medical

Alcohol Use: ☐Heavy ☐Moderate ☐Never ☐Occasionally ☐Past Abuse ☐Daily ☐Rare
Drink alcohol? ☐ No ☐ Daily ☐1-2 x/week ☐1-2 x/year

Tattoos?☐ Location: _____ Piercings? ☐ Location:_____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

ALLERGY / MEDICATION RECORD

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

ALLERGIES

Please List All ALLERGIES and Reactions:

☐ **No Known Drug Allergies**

Medication	Reaction

Are you allergic to Egg, Egg Products, or Poultry? ☐ **No** ☐ **Yes** **Reaction:** _____

Are you allergic to Latex? ☐ **No** ☐ **Yes** **Reaction:** _____

Are you allergic to any Metals? ☐ **No** ☐ **Yes** **Reaction:** _____

Have you ever had a reaction to costume jewelry? ☐ **No** ☐ **Yes** **Reaction:** _____

Please list any other allergies: _____

PHARMACY YOU USE: _____ **PHARMACY ADDRESS:** _____

MEDICATIONS

Please list all prescription medications, supplements, and over-the counter medications you take on a daily basis:

☐ **No Medications**

Medication	Dosage	Frequency

Patient Signature: _____ **Date:** _____