

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF SO, DID YOU FILE A CLAIM?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IS THIS AN AUTO INJURY?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF SO, DID YOU FILE A CLAIM?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

TELL ME ABOUT YOUR FOOT PROBLEMS:

Please answer EVERY question on this form; it is required by your insurance company

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

Affected Side: Right (R) or Left (L) or Both (Circle one)

(Note: please answer for each foot separately if both sides are affected)

1. How would you characterize the onset of your foot pain?

- L R Sudden
L R Gradual
L R Unknown

2. What has the pattern of your foot pain been?

- L R Increasing
L R Decreasing
L R Unchanging
L R Episodic

3. About how long has your foot pain hurt you?

Any prior injuries to this extremity?

Yes _____ No

4. Does your foot problem cause you to fall?

Yes No

5. What relieves your foot pain?

- L R Nothing
L R Heat
L R Ice
L R Modification of activity
L R Lying down
L R Sitting
L R Walking assistive device
L R Exercise
L R Standing
L R Walking
L R Topical ointments
L R Lidoderm patch
L R Medication
L Other: _____
R Other: _____

6. Rate your foot pain 6 months ago.

- L none=0 1 2 3 4 5 6 7 8 9 10=severe
R none=0 1 2 3 4 5 6 7 8 9 10=severe

7. Rate your average foot pain over the last week?

- L none=0 1 2 3 4 5 6 7 8 9 10=severe
R none=0 1 2 3 4 5 6 7 8 9 10=severe

8. What best describes your foot pain?

- L R Aching
L R Sharp
L R Throbbing
L R Burning
L R Tingling
L R Intermittent
L R Constant
L Other: _____
R Other: _____

9. What aggravates your foot pain?

- L R Sitting
L R Twisting
L R Getting out of a chair
L R Getting in/out of a car
L R Riding in a car
L R Prolonged walking
L R Climbing stairs
L R Descending stairs
L R Changes in weather
L Other: _____
R Other: _____

10. What are the associated features of your foot pain?

- L R Keeps me from sleeping at night
L R Frequently awakens me from sleep
L R Stiffness
L R Swelling
L R Catching
L R Locking
L R Giving way
L R Limping
L R Grinding
L R Decreased range of motion
L R Swelling in the leg
L R Difficulty shopping
L R Difficulty doing housework
L R Difficulty with sports
L R Difficulty walking a distance

Continued on back side

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

11. How far can you walk without pain?

- < 100 feet
- 100-200 feet
- > 200 feet

12. What initially brought on your foot pain?

- L R Not sure
- L R Trauma
- L Other: _____
- R Other: _____

13. What previous diagnostic tests have you had on your foot?

- L R None
- L R Plain radiographs
- L R MRI
- L R CT scan
- L R Bone scan

14. How would you characterize your foot problem?

- L R An inconvenience
- L R More than an inconvenience
- L R Disabling

15. Note if any of the following have evaluated or treated your back or lower extremities:

- Orthopedic surgeon
- Neurosurgeon
- Neurologist
- Rheumatologist
- Chiropractor
- Pain management physician
- Other: _____

16. Have you had physical therapy for your foot?

- Yes (If yes, when?) No
- Start date: _____ End date: _____
- Location: _____

17. Have you had any previous foot surgery?

- Yes No

18. Which assistive device do you use?

- None
- Cane
- Crutch
- Walker
- Wheelchair
- Shopping basket

19. What medications have you taken?

	Helped	Did not
_____ None	<input type="checkbox"/>	<input type="checkbox"/>
_____ Tylenol	<input type="checkbox"/>	<input type="checkbox"/>
_____ Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
_____ Motrin	<input type="checkbox"/>	<input type="checkbox"/>
_____ Aleve	<input type="checkbox"/>	<input type="checkbox"/>
_____ NSAID	<input type="checkbox"/>	<input type="checkbox"/>
_____ Ultram	<input type="checkbox"/>	<input type="checkbox"/>
_____ Narcotic: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____ Glucosamine	<input type="checkbox"/>	<input type="checkbox"/>
_____ Steroid injection	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

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	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Lungs, Breathing Disorders, Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease / CHF / MI	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
CVA / Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Numbness / Tingling/ Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Neurological/Psychological Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression/Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bleeding Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Gastrointestinal Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Arthritis / Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Polio / TB / AIDS / Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Skin Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bowel / Bladder Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Kidney Disease / Dialysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Sleep Apnea	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
C-PAP	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
History of MRSA	<input type="checkbox"/> No <input type="checkbox"/> Yes	if yes, date of last nasal swab ____ / ____ / ____
Other – please explain	<input type="checkbox"/> No <input type="checkbox"/> 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: _____