HOOSIER FOOT AND ANKLE

NEW PATIENT REGISTRATION

(PLEASE PRINT)

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DOB:
ADDRESS:	CITY:	STATE:	ZIPCODE:
HOME PHONE:	CELL PHONE:		
SSN#:	EMAIL:		
RACE: ◯American Indian or Alaskan Native ◯Native Hawaiian or Pacific Islander ◯Black or African ◯Caucasian			
PREFERRED LANGUAGE:			
ETHNICITY: ◯Hispanic/Latino ◯Not Hispanic/Latino			
EMPLOYER:	PHONE:		

INSURANCE SUBSCRIBER:

INSURANCE CARRIER:	POLICY #:	GROUP #:
POLICY HOLDER'S NAME:	DOB:	SSN #:

SECONDARY INSURANCE

INSURANCE CARRIER:	POLICY #:	GROUP #:
POLICY HOLDER'S NAME:	DOB:	SSN #:

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:	
HOME PHONE:	CELL PHONE:	WORK PHONE:
◯EMERGENCY CONTACT	◯RELEASE OF MEDICAL RECORDS	◯PRIMARY CONTACT
◯LEGAL GUARDIAN	◯RESIDES WITH	◯PRIMARY CAREGIVER

PRIMARY CARE DOCTOR:	PHONE:
REFERRAL SOURCE:	

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 Hoosier Foot& Ankle or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT HISTORY

TOBACCO USE:	**ALCOHOL USE:**

◯Currently Smoke:	Packs Per Day:	◯Heavy
◯Former Smoker	Quit Date:	◯Moderate
◯Never Smoked		◯Ocasionally
◯Smokless Tobacco		◯Former User

Height:	
Weight:	
Shoe Size:	
Shoe Style:	

FAMILY HISTORY: (please circle all that applies)

M/F	Alcoholism	M/F	Disorder of the Respiratory System
M/F	Anesthesia Complications	M/F	Heart Disease
M/F	Arthritis	M/F	Neurological Disorder
M/F	Cancer	M/F	Siezure Disorder
M/F	Diabetes		

PATIENT ILLNESSES: (please check all that apply)

◯ Alcoholism	◯ Hypothyroidism
◯ Allergic Rhinitis	◯ Ingrown Toenail
◯ Amputation	◯ Keratosis
◯ Anemia	◯ Kidney Disease
◯ Anxiety	◯ Liver Disease
◯ Arthritis	◯ Low Blood Pressure
◯ Asthma	◯ Lung/Respiratory Problems
◯ Bleeding Disorder	◯ Menopause
◯ Cancer	◯ Migraines/Headaches
◯ Cellulitits	◯ Multiple Sclerosis
◯ Congestive Heart Failure	◯ Murmur
◯ COPD	◯ Mycosis
◯ Cystic Fibrosis	◯ Narcolepsy
◯ Depression	◯ Nasal Sinus Problems
◯ Diabetes	◯ Nerve Injury
◯ Diverticulitis	◯ Neurological Disorder
◯ Ear Problems	◯ Neuropathy
◯ Fungul Infections	◯ Obesity
◯ GERD	◯ Osteoarthritis
◯ General Cardiovascular Problems	◯ Osteoporosis
◯ Glaucoma	◯ Pancreatic Disorder
◯ Gout	◯ Parasthesia
◯ Hearing Loss	◯ Parkinson's Disease
◯ HIV/AIDS	◯ Peripheral Vascular Disease
◯ High Cholesterol	◯ Pnuemonia
◯ High Blood Pressure	◯ Psoriasis
◯ Hyperthyroidism	◯ Restless Leg Syndrome
◯ Hypoglycemia	◯ Sarcoidosis
◯ Siezure Disorder	◯ Tremor
◯ STD	◯ Tuberculosis
◯ Skin Discoloration	◯ Ulcers
◯ Sleep Apnea	◯ Urinary Incontinence
◯ Stomach Problems	◯ Varicose Veins

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◯ Stroke ◯ Warts
◯ Thyroid Disease

OPERATIONS

Please List All Surgeries, Dates And Facility

Surgery	Date/Facility

ALLERGIES

Medical Allergies	Reaction

Are you allergic to Betadine? Y/N
Are you allergic to Latex? Y/N
Have you ever had complications with anesthesia?

Medications

Medication Name	Dosage

Pharmacy Name:
Pharmacy Address:
Pharmacy Phone:

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

◯Spouse _____
◯Child _____

◯Other _____
◯Information is not to be released

The ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call:

- ◯ my home
- ◯ my work
- ◯ my cell

You may:

- ◯ leave detailed message
- ◯ leave message with spouse/child/parent
- ◯ leave message asking me to return your call
- ◯ _____

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

M/F

M/F

◯Never

d)