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:
- O American Indian or Alaskan Native
- O Native Hawaiian or Pacific Islander
- O Black or African
- O Caucasian

PREFERRED LANGUAGE:

ETHNICITY: O Hispanic/Latino O Not Hispanic/Latino

EMPLOYER: PHONE:

RESPONSIBLE PARTY/INSURANCE CARRIER

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

SECONDARY INSURANCE

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

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:	
HOME PHONE:	CELL PHONE:	WORK PHONE:

- O EMERGENCY CONTACT
- O LEGAL GUARDIAN
- O PRIMARY CONTACT
- O RELEASE OF MEDICAL RECORDS
- O RESIDES WITH
- O PRIMARY CAREGIVER

PRIMARY CARE DOCTOR:	PHONE:
REFERRAL SOURCE: INTERNET/CURRENT PATIENT/PHYSICIAN/HFA EMPLOYEE/OTHER (PLEASE CIRCLE)	
NAME OF PERSON REFERRING:	
WEBSITE:	

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:

O Currently Smoke: Packs Per Day:
O Former Smoker Quit Date:
O Never Smoked
O Smokeless Tobacco

ALCOHOL USE:

O Heavy O Never
O Moderate
O Occasionally
O Former User

RECREATIONAL DRUG USE:

O Currently User
O Former User
O Never

Height:
Weight:
Shoe Size:
Shoe Style:

Marital Status: O Single O Married O Divorced O Widowed

FAMILY HISTORY: (please circle all that applies)

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

PATIENT ILLNESSES: (please check all that apply)

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

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:

- O Spouse
- O Child
- O Other _____
- O Information is not to be released

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

MESSAGES

Please call:

- O my home
- O my work
- O my cell

You may:

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

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____