

**Patient Registration Form:** *This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be release without your permission.*

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Social Security #: \_\_\_\_\_ Marital Status:  Married  Single  Minor  Widow

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

**Emergency contact information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Patient's Parent/ Guardian Information:** *(if under 18)*

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Demographics:** *(for governmental statistical analysis)*

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

**Pharmacy/ Prescription Information:**

Rite Aid  CVS  Walmart  Target  Other: \_\_\_\_\_

Address or Cross Streets: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Payment Information:**

***Primary Insurance -***

Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff. Date: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  other: \_\_\_\_\_

Insurance Type:  PPO  EPO  HMO  POS  Self Pay  Medicare

***Secondary Insurance -***

Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff. Date: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  other: \_\_\_\_\_

Insurance Type:  PPO  EPO  HMO  POS  Self Pay  Medicare

**How did you hear about the practice? (circle one)**

Internet/Google: \_\_\_\_\_ Friend/Family: \_\_\_\_\_ Doctor Referral (who?): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Facebook: \_\_\_\_\_ Other: \_\_\_\_\_

**Chief Complaint/History of Present Illness:**

What is the reason for your visit? \_\_\_\_\_

Which foot bothers you? \_\_Right \_\_Left How long has it bothered you? \_\_\_\_\_

When does it bother you the most? \_\_\_\_\_ When/what helps alleviate the pain? \_\_\_\_\_

Have you ever been to a Podiatrist before: \_\_ Yes\_\_ No If yes please list: Name: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Athletic activities in which you participate (please list and indicate frequency)

\_\_\_\_\_

Please indicate which foot problems you now have or have had in the past:

<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Cramps/Numbness in feet or legs	<input type="checkbox"/> Ingrown toe nails
<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Flat feet	<input type="checkbox"/> Plantar warts
<input type="checkbox"/> Bunions	<input type="checkbox"/> Foot or leg cramps	<input type="checkbox"/> Swelling in ankles or Feet
<input type="checkbox"/> Corns & Calluses	<input type="checkbox"/> Heel pain	<input type="checkbox"/> Tired feet

**Medical History:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Heart disease    |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Gastritis              | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Depression/Anxiety    | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Ulcer stomach problems | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Bleeding disorder     | <input type="checkbox"/> Pulmonary problems  | <input type="checkbox"/> Nervous condition      | <input type="checkbox"/> HIV/AIDS         |
| <input type="checkbox"/> Inflammation of veins | <input type="checkbox"/> Venereal disease    | <input type="checkbox"/> Frequent infections    | <input type="checkbox"/> Rheumatic fever  |
- Other medical problems: \_\_\_\_\_

Please list all hospitalizations and surgeries with dates:

\_\_\_\_\_

\_\_\_\_\_

Include prescriptions, over the counter medications and vitamins:

\_\_\_\_\_

\_\_\_\_\_

**Are you allergic to any food/medicine:** \_\_\_\_\_

**Social History:**

Do you smoke? \_\_ Yes \_\_ No Do you consume alcohol? \_\_ Yes \_\_ No Do you use drugs? \_\_ Yes \_\_ No  
Is there a possibility you could be pregnant? \_\_ Yes \_\_ No

**Family History:**

<input type="checkbox"/> Inherited disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Other
<input type="checkbox"/> Foot problems	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol	

I have read the above questions and I have answered them to the best of my knowledge. I authorize Drs. Robert Locastro, Eliezer Eisenberger, Emilio Goetz, staff, and associates to examine and treat me. I also authorize the release of any medical information necessary to process medical insurance claims. In case my health insurance policy does not pay or cover my care expenses, I understand that I am responsible for payment.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_