LEG Foot & Ankle Associates, P.C. 4915 Broadway | Suite 1J | New York, NY 10034 | (212) 569-5700

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

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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:

☐ Ankle pain	☐ Cramps/Numbness in feet or legs	☐ Ingrown toe nails
☐ Athlete's foot	☐ Flat feet	☐ Plantar warts
☐ Bunions	☐ Foot or leg cramps	☐ Swelling in ankles or Feet
☐ Corns & Calluses	☐ Heel pain	☐ Tired feet

Medical History:

☐ Anemia	☐ High cholesterol	☐ Stroke	☐ Heart disease
☐ Cancer	☐ High blood pressure	☐ Epilepsy	☐ Thyroid problems
☐ Diabetes	☐ Heart attack	☐ Gastritis	☐ Poor circulation
☐ Depression/Anxiety	☐ Arthritis	☐ Ulcer stomach problems	☐ Hepatitis
☐ Bleeding disorder	☐ Pulmonary problems	☐ Nervous condition	☐ HIV/AIDS
☐ Inflammation of veins	☐ Venereal disease	☐ Frequent infections	☐ 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:

☐ Inherited disease	☐ Cancer	☐ Diabetes	☐ Heart disease	☐ Other
☐ Foot problems	☐ Kidney problems	☐ High blood pressure	☐ 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 Goez, 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:** _____