PATIENT REGISTRATION

Patient Information **Email:**

Last Name:	First Name: MI:
DOB:	SSN: Male [ ] Female [ ]

Full Time AZ Resident? [ ] Yes [ ] No

AZ Address:	City/State:	Zip Code:
Out of State Address:	City/State:	Zip Code:

CONTACT PREFERENCE

Phone #:	Home / Cell / Other	[ ] Primary Contact [ ] Secondary
Phone #:	Home / Cell / Other	[ ] Primary Contact [ ] Secondary

EMERGENCY CONTACT

Name:	Relationship:	Phone #:

EMPLOYER

[ ] Employed - Full Time / Part Time ** Employed outside the home: Y / N **[ ] RETIRED**	
Employer Name:	Phone #:

PHARMACY

Name:	City:	Phone #:
Major Crossroads:		

FAMILY DOCTOR

Name: [MD, DO, PA-C, NP, ____]	Phone #:
City/State:	Zip Code:

INSURANCE

** see below for Policy Holder address

Primary:	Secondary:	Tertiary:
Policy holder: Dob: Relationship:	Policy Holder: Dob: Relationship:	Policy Holder: Dob: Relationship:

**** Policy Holder Address if Different (provide below)**

Address: City/State: Zip Code: .

Authorization to Release information and Assignment of Benefits:
I authorize payments of medical benefits to AZ Red Mountain Footcare or its providers for services rendered or to be rendered in the future without obtaining my signature on each claim submitted and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary for treatment. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL CHARGES RELATING TO MY CARE. If this should need to be referred to a collection agency, I will be responsible for any collection and/or legal fees incurred. My signature below indicates that I have read and also understand the office policy and procedures.

RESPONSIBLE PARTY: ____ DATE: __________________________

Last Name:	First:	DOB:
Height:	Weight:	Age:

PAST MEDICAL HISTORY (check box if history of illness) [ ] NONE

☐ Anemia	☐ Epilepsy	☐ Kidney Disease	☐ Sleep Apnea
☐ Arthritis	☐ Fibromyalgia	☐ Legally Blind	☐ Stomach Ulcer
☐ Asthma	☐ Gout	☐ Liver Disease	☐ Substance Abuse
☐ Bleeding problems	☐ Hearing Impaired	☐ MRSA	☐ Other Conditions Not Listed:
☐ Cancer	☐ Heart Disease	☐ Peripheral Vascular Disease	____________________
☐ COPD	☐ Hepatitis	☐ Raynauds	____________________
☐ DVT	☐ High Blood Pressure	☐ RSD	____________________
☐ Diabetes- Type: ___ I ___II	☐ High Cholesterol		
	☐ Infectious Disease		

MEDICATIONS - Please list your medications by Name.

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

ALLERGIES - Mark any of the following to which you are allergic. [ ] *NO KNOWN DRUG ALLERGIES*

☐ ASPIRIN	☐ EPINEPHRINE	☐ NEOSPORIN	☐ SULFA	☐ OTHER:
☐ AUGMENTIN	☐ KEFLEX	☐ PENICILLIN	☐ TOPICAL IODINE	________________
☐ CODEINE	☐ LATEX	☐ PERCOCET	☐ VICODIN	________________
				________________

SURGICAL HISTORY - Mark any of the following major surgeries you have had. [ ] *NONE*

☐ Ankle	☐ Elbow	☐ Hand	☐ Kidney	☐ Neck	☐ Toe
☐ Back	☐ Eye	☐ Heart	☐ Knee	☐ Shoulder	☐ Other:
☐ Brain	☐ Foot	☐ Heel	☐ Liver	☐ Skin	______________
☐ Cosmetic	☐ Gallbladder	☐ Hip	☐ Lung	☐ Stomach	______________

FAMILY HISTORY - Check M for *Mother* and/or F for *Father*

Arthritis	Bunions	Cancer	Diabetes	Heart Disease	Hypertension	Mother Living [ ] Yes [ ] No
☐ M	☐ M	☐ M	☐ M	☐ M	☐ M	Father Living
☐ F	☐ F	☐ F	☐ F	☐ F	☐ F	[ ] Yes [ ] No

OTHER CONDITIONS: ____.

____.

SOCIAL HISTORY [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Other__________

Living Arrangements:	☐ w/Spouse	☐ Alone	☐ w/Children	☐ Other:
	☐ Significant other	☐ Assisted Living	☐ w/Parents	

TOBACCO USE

[ ] Never [ ] Quit - Year ________ [ ] Yes, I do and have no plan to quit [ ] Yes, I do and plan to quit

LAST NAME:	FIRST:

What conditions are you being seen for today? - Please check box below

☐ Bunion ☐ Diabetic Foot check ☐ Hammertoe	☐ Heel Pain ☐ Infection ☐ Ingrown ☐ Injury	☐ Nail Fungus ☐ 2nd Opinion ☐ Skin & Nail Care	☐ Ulcer/Wound ☐ Other ______________________________ ______________________________________ ______________________________________

Which foot is affected? [ ] Right [ ] Left [ ] Both

How long has it been a problem? ______Days ______Weeks ______Months ______Years

Has this problem been treated before? [ ] Yes [ ] No

Have you ever had foot surgery? [ ] Yes, if yes when __________________ [ ] No

Do you wear orthotics? [ ] Yes [ ] No

Do you do any of the following on a regular basis? - Please check box below

☐ Ballet ☐ Basketball/Baseball/ Football/Soccer ☐ Bowling	☐ Cross-fit ☐ Dancing ☐ Golf ☐ Hike	☐ Martial Arts ☐ Motocross ☐ Racket Sports ☐ Run	☐ Walk for exercise

Does your job involve prolonged standing or walking? [ ] Yes [ ] No

Do you have any other health concerns we need to know about? [ ] Yes, if yes please explain [ ] No

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review or provided with a copy of the Notice of Privacy Practices and that I have read or have had the opportunity to read if I so chose to do so. In singing below, I admit an understanding of the Privacy Practice as it applies to my health records and information.

Patient Name: (PRINT)
Today's Date:
Parent or Authorized Representative: (if applicable)
PATIENT or PARENT/GUARDIAN SIGNATURE:

HIPAA RELEASE

I authorize Medical Information to be disclosed to the following people/persons: (example spouse/parent/child/friend)

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #: