PATIENT REGISTRATION

Patient Information **Email:**

Last Name:	First Name:	MI:
DOB:	SSN:	Male [ ] Female [ ]
Phone #:	Cell:	

Full Time AZ Resident? [ ] Yes [ ] No

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

EMERGENCY CONTACT

Name:	Relationship:	Phone #:

EMPLOYER

[ ] Employed - Full Time / Part Time	[ ] Unemployed	[ ] Student	**[ ] RETIRED**
Employer Name:		Phone #:	

PHARMACY

Name:	City:	Phone #:
Major Crossroads or Address:		

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

MEDICATIONS - Please list your medications by Name.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

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

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

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

FAMILY HISTORY - Check M for *MOTHER* and/or F for *FATHER*

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

OTHER CONDITIONS: _____.

_____.

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

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

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

ALCOHOL HISTORY [ ] YES [ ] NO If Yes, amount _____ per day / week / other _____

LAST NAME:	FIRST:

SHOE SIZE:

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 ** If Yes, [ ] Custom Made [ ] Over the Counter

What physical activity do you do on a regular basis? (example: walking, hiking, pickleball, etc)

_____
_____
_____
_____

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 signing 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)
SIGNATURE: PATIENT // PARENT // GUARDIAN

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 #: