COMPREHENSIVE FOOT & ANKLE CARE
Anne McNamara, D.P.M.
Melissa Winter, D.P.M.
PHONE (239) 275-1114
FAX (239) 275-0498
WWW.MCNAMARAFOOTCARE.COM

NEW PATIENT REGISTRATION FORM

Patient Information and History for Podiatric Examination

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

AGE:_____ SEX:____ DATE OF BIRTH:_____/_____/_____ SSN:_____-_____-_____

HEIGHT:_____ WEIGHT:_____ SHOE SIZE:_____

PHONE- HOME:_____ CELL:_____ OTHER:_____

E-MAIL ADDRESS: _____

LOCAL ADDRESS:_____APT. NUMBER_____

CITY/STATE:_____/_____ ZIP:_____

OUT-OF-STATE ADDRESS (if applicable):_____

CITY/STATE:_____/_____ ZIP:_____

SPOUSE'S NAME:_____SPOUSE'S DATE OF BIRTH: _____/_____/_____

EMERGENCY CONTACT NAME:_____ PHONE:_____

LOCAL PHARMACY:_____PHARMACY PHONE:_____

EMPLOYER NAME:_____OCCUPATION:_____

NAME OF INSURED (if different than self):_____

RELATIONSHIP TO INSURED:_____INSURED DATE OF BIRTH: _____/_____/_____

FAMILY PHYSICIAN NAME:_____ LAST VISIT: _____/_____/_____

REFERRAL SOURCE: _____

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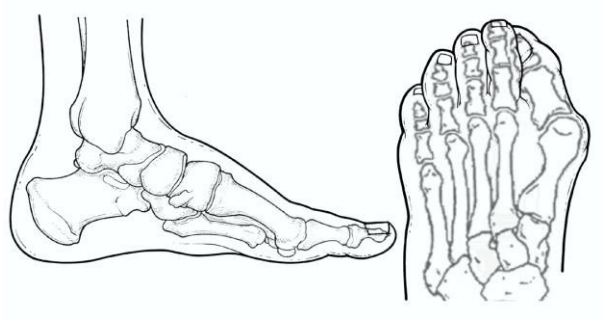
PATIENT NAME:_____ **PATIENT DATE OF BIRTH:**_____/_____/_____

REASON(S) FOR TODAY'S VISIT:_____

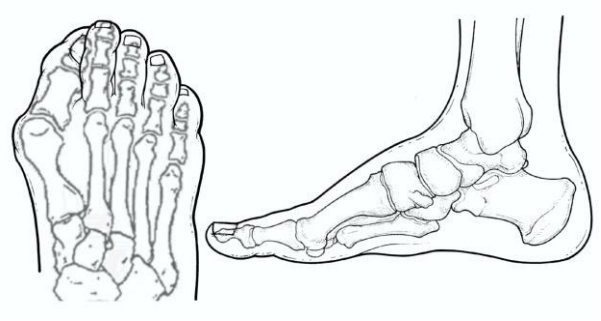
ONSET:_____ **FREQUENCY:**_____

CURRENT TREATMENT:_____

MARK DIAGRAMS BELOW TO INDICATE PROBLEM AREA(S):



LEFT



RIGHT

LIST OF CURRENT MEDICATIONS (including over–the–counter medications):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

LIST OF MEDICATION ALLERGIES/REACTIONS CHECK ALL THAT APPLY:

☐ **PENICILLIN** ☐ **IODINE** ☐ **ASPIRIN** ☐ **CODEINE** ☐ **ERYTHROMYCIN** ☐ **SULPHA**
☐ **CORTISONE** ☐ **ADHESIVE TAPE** ☐ **LIDOCAINE** ☐ **OTHER**_____
REACTION TO ABOVE:_____

IF NO KNOWN MEDICATION ALLERGY/REACTION CHECK HERE: ☐

Circle ANY of the following: Metal, Clips, Defibrillator, Pacemaker, Stent, NONE ☐

ALCOHOL USE: YES / NO

AMT: _____PER DAY

TOBACCO USE: YES / NO IF "NO", HAVE YOU EVER SMOKED? YES / NO

AMT: _____PER DAY

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PATIENT NAME:_____ **PATIENT DATE OF BIRTH:**_____/_____/_____

LIST RECENT SURGERIES INCLUDING THE FOOT (date and description):

_____

_____

_____

_____

ILLNESS (check all that apply):

MAJOR DISEASE:
- ☐ DIABETES
- ☐ HYPERTENSION
- ☐ ANGINA
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ ARRHYTHMIA
- ☐ MITRAL VALVE PROLAPSE
- ☐ HEART MURMUR
- ☐ AIDS/HIV
- ☐ AUTOIMMUNE DISORDER

VASCULAR:
- ☐ POOR CIRCULATION
- ☐ ANEMIA
- ☐ SICKLE CELL
- ☐ ULCERATIONS
- ☐ BLOOD CLOTS
- ☐ BLEEDING DISORDERS
- ☐ NIGHT CRAMPS
- ☐ STROKE

RESPIRATORY:
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ EMPHYSEMA
- ☐ TUBERCULOSIS
- ☐ LUNG DISEASE
- ☐ SHORT OF BREATH
- ☐ FREQUENT COLDS

GASTROINTESTINAL:
- ☐ ACID REFLUX
- ☐ BOWEL DISORDERS
- ☐ ULCERS
- ☐ GI OR RECTAL BLEEDING
- ☐ STOMACH PROBLEMS
- ☐ OTHER

HEENT:
- ☐ EAR OR HEARING
- ☐ EYE PROBLEMS
- ☐ HEADACHES / MIGRAINE
- ☐ OTHER

ARTHRITIS:
- ☐ GOUT
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID
- ☐ OTHER

PSYCHOLOGICAL:
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PSYCHIATRIC CONDITION
- ☐ ALCOHOL DEPENDENCE
- ☐ DRUG DEPENDENCE

MISCELLANEOUS:
- ☐ HIATAL HERNIA
- ☐ EPILEPSY
- ☐ THYROID
- ☐ HEPATITIS
- ☐ PROSTATE
- ☐ CANCER
- ☐ MUSCLE DISEASE
- ☐ SKIN PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ KIDNEY PROBLEMS
- ☐ OTHER

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PATIENT NAME:_____ PATIENT DATE OF BIRTH:_____/_____/_____

Please READ & INITIAL next to <u>each</u> line below.

_____ I hereby give my permission to the podiatrists of Comprehensive Foot & Ankle Care and any appointed assistants to administer treatment and to perform such procedures as may be deemed necessary in the treatment of my foot and/or ankle disorder.

_____I hereby assign to the above named physician all benefits provided by my insurance company policy or policies (including Medicare) for such treatment, and authorize the release of any medical information necessary to process my insurance claim.

_____I understand that I am responsible for paying all co-payments, deductibles, and non-covered services, and that payment is to be made in full at the time of service.

_____ I further understand that if I am found in default of payment, I am responsible for all costs associated with monetary collection including but not limited to: Balance (s) due, attorney fees, and a collection agency fee of 30%.

_____ Missed appointments \ Cancelled appointments without 24 hours' notice will be charged a $50 fee.

_____I have been offered this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

*** By initialing above and signing below you are agreeing that you understand these notices as they've been outlined for you.**

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**