

# PATIENT REGISTRATION FORM FOR BEECH TREE PODIATRY, P.C.

## PATIENT INFORMATION

TODAY'S DATE: \_\_\_\_\_  
MARITAL STATUS: *S M W D* SEX: *M F*

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL # \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ WORK # \_\_\_\_\_

EMPLOYER / OCCUPATION \_\_\_\_\_

WHO IS YOUR FAMILY PHYSICIAN? \_\_\_\_\_

REFERRAL SOURCE (DOCTOR, FRIEND, ETC): \_\_\_\_\_

MY MAIN CONCERN WITH MY FEET IS \_\_\_\_\_  
HAVE YOU HAD PREVIOUS CARE FOR THIS? YES or NO (*please circle*)

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

SHOE SIZE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

## INSURANCE:

1. INSURANCE CO. \_\_\_\_\_ ID # \_\_\_\_\_ GRP # \_\_\_\_\_

2. INSURANCE CO. \_\_\_\_\_ ID # \_\_\_\_\_ GRP # \_\_\_\_\_

## PATIENT HISTORY

<p><b>ALLERGIES:</b> (<i>please circle</i>)</p> <p>ASPIRIN, ADHESIVE TAPE, IODINE, PENICILLIN, SULFA DRUGS, LATEX, NOVOCAINE, OTHER _____</p> <p>REACTIONS _____</p> <p><b>PLEASE LIST ANY RECENT HOSPITALIZATIONS:</b></p> <p>1. _____ 2. _____ 3. _____</p> <p><b>PLEASE LIST ALL SURGERY THAT YOU HAVE HAD:</b></p> <p>1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>	<p><b>ADULTHOOD OR CHILDHOOD ILLNESSES:</b> (<i>Please circle</i>)</p> <p>DIABETES, MEASLES, HEART TROUBLE, ASTHMA, AIDS OR HIV, ARTHRITIS, STROKE, EPILEPSY, KIDNEY DISEASE, MUMPS, BLADDER TROUBLE, STOMACH TROUBLE, CLOTTING DISORDERS, BLOOD CLOTS, POLIO, HEPATITIS, CANCER, HIGH BLOOD PRESSURE, STD'S, SCARLET FEVER, RHEUMATIC FEVER</p> <p>OTHER _____</p> <p><b>MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS:</b></p> <p>1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____</p>
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<b>FAMILY HISTORY:</b> <i>(please circle)</i> ARTHRITIS, DIABETES, HEART DISEASE, GOUT, CANCER, HIGH BLOOD PRESSURE, BLEEDING DISORDERS, ANEMIA/SICKLE CELL, OTHER _____	<b>SOCIAL HISTORY:</b> DO YOU SMOKE? YES OR NO HOW MUCH _____ DO YOU DRINK ALCOHOL? YES OR NO HOW OFTEN _____ DRUG USE? YES OR NO WHICH _____ HOBBIES: _____
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ARE THE HEALTH CONCERNS RELATED TO: AN AUTO ACCIDENT? \_\_\_\_\_ LIABILITY? \_\_\_\_\_  
 WORKER'S COMPENSATION? \_\_\_\_\_ OTHER? \_\_\_\_\_

**AUTHORIZATIONS:**

1. I verify all information provided by myself to be true and accurate. I hereby authorize Beech Tree Podiatry, P.C. to furnish information to insurance carriers concerning my illness and treatment. I also hereby assign to Beech Tree Podiatry, P.C. all payments for medical services rendered to myself or my dependents.
2. I hereby give permission to Beech Tree Podiatry, P.C. to examine and treat my feet medically, surgically or orthopedically and to administer treatment. I also give permission for them to perform such minor operative procedures as may be necessary in the diagnosis and treatment of my condition.

\_\_\_\_\_  
**Signature of Patient/ Guardian/ Responsible Party**

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

**FOR MEDICARE PATIENTS:**

I request that payment of authorized Medicare benefits be made on my behalf to Beech Tree Podiatry, P.C. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
**Beneficiary's signature**

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

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR BEECH TREE PODIATRY, P.C.**

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read ( or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
**Print name**

\_\_\_\_\_  
**Signature (to be signed in the office)**

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