**Patient Registration**

**Name**: _____
Last First Middle

**Date Of Birth**: _____ **Gender:** ○M ○F **Marital Status**: _____

**Social Security Number:** _____ **Driver's License/ID**: _____

**Street Address:** _____ **City**: _____ **State:** _____ **Zip**: _____

**Home Phone**: _____ **Cell Phone**: _____

**Work Phone**: _____ **Primary Language:** _____

**Email Address:** _____ **Ethnicity:** ○ Hispanic/Latino ○ Non-Hispanic/Latino

**Race:** ○American Indian ○Asian ○African American ○ Native Hawaiian ○ White ○ other

**Employment Status**: _____

Employer: _____ Occupation: _____

Street Address: _____ City: _____ State: _____ Zip: _____

**Emergency Contact:**

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

**Referring Physician:** _____ **Other Treating Physician:** _____

**Primary Insurance:** ○HMO ○POS/PPO ○EPO ○Medicare ○Cash ○Other

Insurance Company Name: _____ Group Number: _____

Policy/ID Number: _____

**Secondary Insurance:** ○HMO ○POS/PPO ○EPO ○Medicare ○Cash ○Other

Insurance Company Name: _____ Group Number: _____

Policy/ID Number: _____

**Primary Insurance Subscriber:** _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Employment Status: _____ Employer: _____

Job Title: _____

*I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that* ***I am responsible for knowing my benefits / coverage and test ordered by my physician may NOT be covered.*** *I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.* ***Payment is due at the time services are rendered.*** *All charges are the direct responsibility of the patient. Fullerton Foot and Ankle cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. I hereby acknowledge that I have read, understand and agree to give consent for treatment.*

**Patient Signature:** _____ **Date:** _____

# Health History

Reason for Today's Visit:

_____

_____

**Allergies:** Any known drug allergies? ○Yes ○No
*Please list all allergies including food, medications, and environmental and reaction.*

_____

_____

**Do you currently take any medications on a regular basis?** ○Yes ○No
*If yes please list any medications that you currently take on a regular basis (include non-prescriptions).*

| Medication | Dosage | For |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medical History**
**Illnesses & Conditions –** Do you ever have or have you ever had any of the following:

○ Hypertension
○ Heart Disease
○ Arthritis If Yes, please explain: _____
○ Diabetes If Yes, please explain: _____
○ Assistive Devices If Yes, please explain: _____
○ Skin Complications If Yes, please explain: _____
○ Respiratory If Yes, please explain: _____
○ Cardiovascular If Yes, please explain: _____
○ Urinary Complications If Yes, please explain: _____
○ Gastroenterology If Yes, please explain: _____
○ Muscoskeletal If Yes, please explain: _____
○ Neurology If Yes, please explain: _____
○ Psychiatry If Yes, please explain: _____
○ Hematology If Yes, please explain: _____
○ Infectious Disease If Yes, please explain: _____
○ Rheumatology If Yes, please explain: _____
○ HEENT If Yes, please explain: _____

**Surgical History:**

| **Procedure:** | **Year:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family History:**

Do you have any family history of serious Illness? ○ No ○ Yes

If yes, list below:

| | Mother | Father | Maternal Grandparent | Paternal Grandparent |
|---|---|---|---|---|
| Alcoholism | ○ | ○ | ○ | ○ |
| Alzheimer's | ○ | ○ | ○ | ○ |
| Asthma | ○ | ○ | ○ | ○ |
| Bleeding Problems | ○ | ○ | ○ | ○ |
| Cancer (Type: _____) | ○ | ○ | ○ | ○ |
| Diabetes | ○ | ○ | ○ | ○ |
| Dementia | ○ | ○ | ○ | ○ |
| Heart Attack | ○ | ○ | ○ | ○ |
| Heart Disease | ○ | ○ | ○ | ○ |
| High Blood Pressure | ○ | ○ | ○ | ○ |
| Osteoporosis | ○ | ○ | ○ | ○ |
| Seizures | ○ | ○ | ○ | ○ |
| Stroke | ○ | ○ | ○ | ○ |
| Thyroid | ○ | ○ | ○ | ○ |

**Social History:**

Do you or have you ever smoked or chewed tobacco? ○ Yes ○ No How Many? _____

Do you or have you ever used recreational drugs? ○ Yes ○ No Type: _____

How often? _____

Do you drink alcohol? ○ Yes ○ No Type: _____

How much per Day? _____/____years

**Appointment Reminders:**

*I would like to receive appointment reminders* ○ Yes ○ No Preferred Phone: _____

**Pharmacy:**

Preferred Pharmacy: _____Phone: _____ Fax: _____

Address: _____City: _____ State: _____ Zip: _____

If unaware of phone number please note cross streets: _____