Central DuPage Foot & Ankle Associates

Patient Registration Form

Patient Information

Name:

____

(First) (M.I.) (Last)

Gender: ☐ Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

DOB: ______________________ SS # (Required for All Patients): _________________________________

Responsible Party (if a minor): ____

Email: ____

Street Address: ____

City, State, Zip: ____

Primary Phone: _______________ ☐Cell ☐Home☐Business **Can we leave a message:** ☐Yes ☐No

Other Phone: _______________ ☐Cell ☐Home☐Business **Can we leave a message:** ☐Yes ☐No

Emergency Contact:

____

(Name) (Phone Number)

How did you hear about our office?: ____

Government Requested Data:

Preferred Language_______________ **Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Other:___________

Race: ☐American Indian/Alaskan Native ☐ Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐ White ☐Other:________

☐**Declined**

Insurance Information

Primary Insurance:

Insurance Company and Address:____

Insured Name:___________________________ DOB:___________ Relationship to Patient:______________

Member ID:___________________________________ Group #:___________________________________

Secondary Insurance:

Insurance Company and Address:____

Insured Name:___________________________ DOB:___________ Relationship to Patient:______________

Member ID:___________________________________ Group #:___________________________________

Medical History

Reason for visit today: ____

Age: _____________ Height:______________ Weight:_______________ Shoe Size:_______________

Primary Care Physician: ____

Address of Primary Care: ____

We will be happy to take a copy of your physician's business card if available.

Phone Number: _____________________________Date you last saw your primary doctor:___________

Pharmacy Name and Address: ____

Past Surgical History: ____

Patient's Current and Past Medical History (check all that apply):

☐Diabetes	☐Bleeding Disorders	☐Hepatitis	☐Lung Problems	☐ Stroke	☐Cancer
☐Arthritis	☐Kidney Disease	☐Hypertension	☐Neck Pain	☐ Back Pain	☐Gout
☐Asthma	☐Numbness in Feet	☐Heart Disease	☐Anemia	☐ Liver Disease	☐Other
☐Poor Circulation					

Mother's Medical History (check all that apply):

☐Diabetes	☐Bleeding Disorders	☐Hepatitis	☐Lung Problems	☐ Stroke	☐Cancer
☐Arthritis	☐Kidney Disease	☐Hypertension	☐Neck Pain	☐ Back Pain	☐Gout
☐Asthma	☐Numbness in Feet	☐Heart Disease	☐Anemia	☐ Liver Disease	☐Other
☐Poor Circulation					

Father's Medical History (check all that apply):

☐Diabetes	☐Bleeding Disorders	☐Hepatitis	☐Lung Problems	☐ Stroke	☐Cancer
☐Arthritis	☐Kidney Disease	☐Hypertension	☐Neck Pain	☐ Back Pain	☐Gout
☐Asthma	☐Numbness in Feet	☐Heart Disease	☐Anemia	☐ Liver Disease	☐Other
☐Poor Circulation					

Social History: Do you currently smoke? ☐No ☐ <5 cigarettes/day ☐.5 pack/day ☐1 pack/day ☐>1 pack/day

Do you drink alcohol? ☐No ☐Yes If yes, how many drinks per week?_________________________

Have you had the Influenza vaccination this year? ☐No ☐Yes If yes, date:________________________________

Have you had the Pneumonia vaccination this year? ☐No ☐Yes If yes, date: _____________________________

Have you experienced 2 falls OR any falls with injury in the last year? ☐No ☐ Yes

If yes, please provide details:____

Authorization to Disclose Health Information

I authorize Central Dupage Foot and Ankle Associates, P.C. to discuss my medical care with the following:

Name:____ Relationship:______________________________

Name:____ Relationship:______________________________

Name:____ Relationship:______________________________

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Central Dupage Foot and Ankle Associates Medical Information Privacy Notice for my review prior to receiving services.

SIGNATURE OF PATIENT/GUARDIAN:____

PRINT NAME:____ DATE: ____________________________

RELATIONSHIP TO PATIENT:____

Do you have a living will? ☐No ☐Yes

I verify that the above information is true to the best of my knowledge. I hereby give my permission to Central Dupage Foot and Ankle Associates, P.C., to perform diagnostic, therapeutic and/or operative procedures as may deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

SIGNATURE OF PATIENT/GUARDIAN____

PRINT NAME:____ DATE: ____________________________

RELATIONSHIP TO PATIENT:____