GLACIER FOOT AND ANKLE

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's name: (last)_____(first)_____(mi)_____
Marital status (circle): Single Married Widowed Divorced Separated
Is this your legal name? Yes No If not, what is your legal name?_____

Birthdate___/___/___ **Age**___**SSN:**_____**Gender:** Male Female

Street address_____City_____State_____Zip_____
P.O. Box_____City_____State_____Zip_____Home phone(___)_____

Occupation_____**Employer**_____Work phone(___)_____
E-mail address_____**Race**_____Cell phone (___)_____

Ethnicity: Hispanic/Latin NOT Hispanic/Latin **Language**_____**Pharmacy**_____

INSURANCE INFORMATION

Person responsible for bill:_____Birthdate___/___/___
Address (if different)_____Home phone(___)_____
Occupation_____**Employer**_____Work phone(___)_____
Employer address_____Is this person a patient here? Y N

Is this person covered by insurance? Y N
Please indicate primary insurance_____
Subscriber's name_____**Subscriber's SSN**_____
Birthdate___/___/___ **Group #**_____**Policy#**_____**Co-pay$**_____
Patient's relationship to subscriber: Self Spouse Child Other_____

Name of secondary ins. (if applicable) Subscriber_____Grp_____Pol#_____
Patient's relationship to subscriber: Self Spouse Child Other_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)_____
Relationship to patient_____Home # (___)_____Work #(___)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Glacier Foot and Ankle or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

MEDICAL HEALTH & HISTORY

Describe Problem:

Right Foot_____

Left Foot_____

Referred by:_____Physician **Date last seen by PCP:**_____

List the medications you are currently taking (including birth control):

Name	Strength	Formulation	Take how often

Medical History:

Are you, or have you been treated for (circle):

Gout
Reaction to Anesthesia
Hepatitis (type?)
Liver Disease-Jaundice
Epilepsy-Seizures
Kidney Trouble
Sleep Apnea
Emphysema-Bronchitis
COPD
Asthma
Tuberculosis
Skin Rashes-Hives-Eczema
Scarring Tendency
HIV-Aids-Venereal disease
Thyroid Problem

Women, are you pregnant?
" " breastfeeding?

Diabetes
yrs_____type_____
High Blood Pressure
High Cholesterol
Heart Problems
type_____
Heart Attack-Stroke
Pacemaker
Artificial Heart Valve
Stomach Ulcers
Artificial Joints
Arthritis-Lupus-MS
Rheumatic Fever
Cancer-Tumor
Blood Clot-DVT-Phlebitis
Bleeding Problem
Anemia

Allergy:

Are you allergic to, or have you reacted adversely to any of the following? (circle)

Penicillin
Sulfa Drugs
Other Antibiotics_____
Codeine

Aspirin
Anti-inflammatory
Iodine
Sedatives

Local Anesthesia
Latex
Tape-Band Aids
Other_____

Type of Reaction_____

Surgical History (last 3 years):_____

_____

MEDICAL HEALTH & HISTORY

Hospitalization (last year):_____

Family History:

Who, in your family has any of the following, or something not listed here?

Heart Disease	**Who**_____
Diabetes	**Who**_____
High Blood Pressure	**Who**_____
Cancer	**Who**_____
Foot Problems	**Who**_____
Blood Clots	**Who**_____
Rheumatoid Arthritis	**Who**_____

Social History (circle):

Do you smoke? Yes No If so, how many each day?_____How long?_____
Do you drink alcohol? Yes No If so, how much?_____How often?_____
Living Arrangement_____History of Substance Abuse Yes No

Vitals

Weight_____ **Height**_____ **Shoe Size**_____

Primary care Physician_____ **Date last saw** _____

Any current symptoms of (circle):

General: Fever Chills Fatigue Unexplained Weight loss or Weight gain

Ear-Nose-Throat: Discharge Nose bleeds Difficulty swallowing Swollen glands

Cardiovascular: Chest pain Palpitations Ankle swelling Murmur

Respiratory: Shortness of breath Chronic cough Wheezing Phlegm

Hematology: Bleed easily Bruising Swollen glands Anemia

Musculoskeletal: Joint Swelling / Pain Muscle aches Back Pain Weakness

Skin: Rash Itching Lumps / Growths Moles Lesions

Gastrointestinal: Nausea Vomiting Heartburn Abdominal pain Blood in stool Diarrhea Constipation Yellow runny stool

Genitourinary: Kidney stones Blood in urine Painful urination Incontinence

Neurology: Tingling Numbness Seizures Headaches Balance issues

Endocrinology: Excessive thirst Excessive urination Insomnia

Psychiatry: Depression Anxiety Suicidal thoughts Substance abuse

Is there anything you would like to add or explain? _____

_____