ASTRO FOOT CARE, PA

TODAY'S DATE: ____/____/____

REGISTRATION FORM

(Please print clearly)

EMAIL ADDRESS:

PATIENT INFORMATION

Patient's Last Name	First	Middle	Race/Ethnicity

Street Address	City	State	Zip Code

Home Phone #	Cell Phone #	Work Phone #	IF M.D. ANDERSON PT, INDICATE MRA #:
( ) -	( ) -	( ) -	

Date of Birth	Age	Social Security #	Marital Status	Gender
/ /		/ /	☐Single ☐Married ☐Widow ☐Divorced	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured's Employer

Insured's Employer's Address

PLEASE INDICATE PRIMARY INSURANCE:

Insurance Name	Customer Service #(back of card)	ID #	Group #

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE INDICATE SECONDARY INSURANCE:

Insurance Name	Customer Service #(back of care)	ID#	Group #

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Does your plan require a referral? ☐ Yes ☐ No

If Yes, was a referral obtained? ☐ Yes ☐ No

Referral #:

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name	Primary Care Physician's Phone Number
	( ) -

Primary Physician's Street Address	City	State	Zip Code

Date of last physical exam	Date of last blood test
____/____/____	____/____/____

WHO REFERRED YOU TO OUR PRACTICE?

☐ Doctor _____ ☐ Friend _____

☐ Hospital _____ ☐ Website _____

☐ Insurance Plan _____ ☐ Other _____

☐ Family _____

ASTRO FOOT CARE, PA

MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	/ /

ALLERGIES *(LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS/FOOD – AND SPECIFIC REATIONS TO THEM*

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Iodine on Skin	☐ Aspirin
☐ Codeine	☐ Tape	☐ Anti-inflammatory Medication	☐ Other:	

If any allergies, what type of reaction? ☐ Difficulty breathing ☐ Rash ☐ Stomach upset

MEDICATION *MEDICATIONS/VITAMINS YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT AND ANKLE HISTORY

What foot/ankle problem brings you to the doctor? **How Long?** Months Years

How have you been treated for the current problem?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

Do you have an X-Rays, MRI, or CT Scan for the current problem? ☐ Yes ☐ No

Shoe size	**Height**	**Weight**

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Cancer (Type):	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes: Type I ☐ Type II ☐	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetic Foot Ulcers	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Stomach Ulcers / Reflux / Heartburn	☐ Yes	☐ No
Heart Disease or Attack	☐ Yes	☐ No	Other:		
Heart Murmur	☐ Yes	☐ No	Other:		
Hepatitis (Indicate) ☐ A ☐ B ☐ C	☐ Yes	☐ No	Other:		

Do you drink?	☐ Yes ☐ No If Yes, Drinks per week
Do you smoke?	☐ Yes ☐ No If Yes, Pack(s)/day
Are you pregnant?	☐ Yes ☐ No If Yes, how far along?
Flu Shot this season?	☐ Yes ☐ No Date? **Pneumonia Shot?** ☐ Yes ☐ No Date?
Are you 65 years or older AND have had a fall within the last year?	☐ Yes ☐ No If Yes, when and how many?
Advanced Directive/Living Will?	☐ Yes ☐ No Appointed Surrogate Name:

PATIENT NAME	BIRTH DATE	/ /

INDICATE ANY SURGICAL PROCEDURES YOU HAVE HAD IN THE PAST

Orthopedic/Podiatric	☐ Yes	☐ No	Circulation (Bypass, Angioplasty)	☐ Yes	☐ No
Heart	☐ Yes	☐ No	Aneurysm	☐ Yes	☐ No
Tumor	☐ Yes	☐ No	Head and Neck	☐ Yes	☐ No
Abdominal	☐ Yes	☐ No	Other:		

Have you ever been put to sleep for surgery? ☐ Yes ☐ No

Any problems with anesthesia? ☐ Yes ☐ No

FAMILY HISTORY

Relative	*Alive*	*Deceased*	*Age Deceased*	*Cause of Death (Heart Problems, Cancer, Diabetes, Etc.)*
Father	☐	☐		
Mother	☐	☐		
Siblings	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

- I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.
- I authorize my insurance company to pay benefits directly to Dr. Oliver and I also acknowledge that any non-covered services are my responsibility.
- I acknowledge that I have been informed of the Notice of Privacy Practices and that a copy is available to me upon request.
- I understand that if I fail to notify the office at least 24 hours prior to my appointment time that there will be a charge for “missed business opportunity” of $25.
- I understand that my picture may be taken for identification and treatment purposes.

X	/ /
Patient/Guardian Signature	Date

History Reviewed By: Dr. Signature **Date**

EMERGENCY CONTACT INFORMATION

NAME : _____

RELATIONSHIP: _____

HOME PHONE NUMBER: _____

LOCAL PHARMACY YOU USE

NAME:_____

ADDRESS(or CROSS STREETS):_____

NUMBER:_____