PATIENT REGISTRATION

FORM A-9

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name Last		First		Middle			
	•				ļ		
Parent if Patient is a Mine	or	Today's Date	Date of Birth	Sex	Age		
	.	,		2 2			
Patient's Social Security	atient's Social Security Number California Driver's License No.						
rationt's Social Security	IAGIIIDGI	dell'Offia Driver's License No.					
Home Address		City	State	Zip			
Mailing Address if Different	ent	City	State	Zip			
Home Telephone Number	ər	Work Telephone Number					
Occupation		Empl	oyer's Name	······································			
Employer's Address		City	State	Zip			
Spouse Name	1		Employer				
Other Physician's Name							
Whom May We Thank fo	r Referring You	to Our Practice?					
Email Address:							
NOTIFY IN CASE OF	EMERGENCY						
Name		Rela	tionship		_		
Home Telephone	lome Telephone Work Telephone						
FINANCIAL INFORM	ATION: PERS						
Name		Те	lephone		•		
Address		City	State	Zip			
Insurance Company		Claim Address					
Subscriber's Name	Subs	criber's Date of Birt	h Subscrib	er's SSN#.			
Insurance ID No.:							
Secondary Insurance			Claim Address				
Subscriber's Name	Subs	criber's Date of Birt	h Subscrib	er's SSN#			
Were You Injured on the	Job? YES	NO I	Have you Informed `	Your Employer? Yi	ES NO		
Date of Original Injury:			Address				
Worker's Compensation	Camer Name	•	Address				

ATIENT NAME:			ta.		
				· · · · · · · · ·	
Describe your foot problem:					
a.					•
How long has it been bothering Days	Weeks		Years		
Any past problems of your feet and ankles?	·				
Any past surgical procedures					
		<u> </u>		<u> </u>	
Shoe size Current Weight	Heig	nt			
Are you allergic Any Medicines?					
\$- **	·				
		•	Other?		
Tape? Betadine (ic			04.0	Yes	No
Have you had problems taking aspirin or ibuprofer	(Advil, Motrin)?			Yes	No
Any problems with local anesthetics (Novocaine, L	idocaine)?				
GENERAL HEALTH INFORMATION			Number of	vears?	
Do you have Diabetes? Yes No If yes, do yo	ou take insulin? Yes	s No	Humber of	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Have you had any serious illnesses?					
	16	- forwhal	condition?		
Are you under a physician's care? Yes No					
7 Hydicall	ast saw this Doctor				
May we contact your physician about your health? Yes	No		 		
Name of Pharmacy or Drug Store	Pho	ne#			
What medications do you take regularly?			-		

HAVE YOU EVER HAD ANY	OF T	HE F	OLLOWING?			
ACID REFLUX	Y	N	FIBROMYALGIA	YN	NEUROPATHY Y N	
ANEMIA	Y	N	GOUT	YN	OPEN SORES Y N	
ARTHRITIS	Y	N	HEART ATTACK	YN	PNEUMONIA Y N	
ASTHMA	Y	N	HEART DISEASE/FAILURE	YN	POLIO Y N	
BACK TROUBLE	Y	N	HEPATITIS	YN	RHEUMATIC FEVER Y N	
BLADDER INFECTIONS	Y	N	HIV+/AIDS	YN	SICKLE CELL DISEASE Y N	
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	YN	SKIN DISORDER Y N	
BLOOD CLOTS	Y	N	KIDNEY DISEASE	YN	SLEEP APNEA Y N	
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	YN	STOMACH ULCERS Y N	
BRONCHITIS/EMPHYSEMA	Y	N	Low Blood Pressure	YN	STROKE Y N	
CANCER	Y	N N	MIGRAINE HEADACHES MITRAL VALVE PROLAPSE	YN	THYROID DISEASE Y N TUBERCULOSIS Y N	
DIABETES OTHER CONDITIONS:	11	114	MITRAL VALVE PROLAPSE	YN	TUBERCULOSIS Y N	
Do you have any artificial joint	3 ?	-				
Hip	Yes		No	•	•	
Knee	Yes		No			
Other						
Do you have Heart Valve Impl	ant?	Y	'es No	***	**	
FAMILY HISTORY:						
Mother Living			Deceased	Cause of Death		
Father Living			Deceased	Cause of Death		
Brother Living			Deceased	Cause of Death		
Sister Living			Decessed	Cause of Death		
SOCIAL HISTORY MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED USE OF ALCOHOL: NEVER No LONGER USE HISTORY OF ALCOHOL ABUSE						
☐ CURRENT USE - TYPE ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY						
USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? SMOKEPACKS/DAY FORYEARS						
USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? TYPE * CURRENT USE - TYPE RARE OCCASIONAL MODERATE DAILY						
EMPLOYER:						
					14	
			THEIR CARE? CHILDREN-AG AMILY MEMBER OTHER		☐ PET(S)-WHAT KIND?	
Exercise: Never Rare Occasional weekly Several times a week Daily						
Types of exercis	E:					
FAMILY HISTORY DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS OTHER						
					÷	
Connhum					Date	

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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.

Patient Name (please print)	Date	
Parent or Authorized Representative (if applicable)		
Signature		