

TOWN CENTER FOOT CLINIC

Podiatric physicians and surgeons specializing in the foot and ankle



JOHN D. MOZENA, DPM, FACFAS
JOSHUA P. MITNICK, D.P.M.

PATIENT REGISTRATION FORM

(Confidential information – important for our files and for your health)

Which doctor are you seeing today? Dr. Mozena Dr. Mitnick Either

Patient name _____ Preferred name _____

Birth date ____ / ____ / _____ Age ____ Male Female Marital status _____

Mailing address _____ Phone () _____

City _____ State ____ ZIP _____ Cell phone () _____

Email address _____

Employer _____ Phone () _____

Address _____

Is this a work-related injury? No Yes If so, has a claim been initiated? No Yes

Name & address of nearest relative (not living with you) _____

_____ Phone () _____

Whom may we thank for your referral to our clinic? _____

(We appreciate patient referrals with a complimentary Starbucks gift card)

Who is financially responsible for any fees for services performed here after your insurance company has finished paying? _____

MEDICAL INSURANCE INFORMATION

(Please present your insurance card to the front desk)

1. Insurance name _____

Insured's name _____ ID# _____ Group # _____

2. Additional coverage _____

Insured's name _____ ID# _____ Group # _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the named provider(s) for professional services rendered.

Sign _____

Date _____

RELEASE OF INFORMATION

I authorize the release of any medical information to process this claim.

Sign _____

Date _____

List any major injuries or fractures you have had:

Year	Injury/fracture

Health Habits

<i>Tobacco</i>	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes: Cigarettes – how many packs/day: _____ For how many years: _____
<i>Alcohol</i>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what form and how often?
<i>Activity</i>	What percent of the day (i.e. the time you are awake) are you on your feet?

Family Medical History: List any significant health problem that your blood relatives have had (*for example: heart disease, diabetes, stroke, thyroid disease, cancer, arthritis, foot conditions, etc.*).

Check here if you are adopted or if you don't know your family medical history

	Significant family health problems
Mother	
Father	
Siblings	
Grandmother <i>(Maternal)</i>	
Grandfather <i>(Maternal)</i>	
Grandmother <i>(Paternal)</i>	
Grandfather <i>(Paternal)</i>	

Review of systems – check any symptoms that you are currently experiencing:

<i>General</i>	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Recent weight change
<i>Cardiovascular</i>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Calf pain	<input type="checkbox"/> Leg swelling
<i>Respiratory</i>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing
<i>Head, eyes, nose, throat</i>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Blurred or double vision	<input type="checkbox"/> Hay fever
<i>Gastrointestinal</i>	<input type="checkbox"/> Heartburn/acid reflux	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Abdominal pain
<i>Skin</i>	<input type="checkbox"/> Rash	<input type="checkbox"/> Open sores	<input type="checkbox"/> Dry skin
<i>Musculoskeletal</i>	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Neck pain
<i>Neurological</i>	<input type="checkbox"/> Tremors	<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Numbness or tingling
<i>Endocrine</i>	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Too hot/cold	<input type="checkbox"/> Fatigue/tired
<i>Hematological</i>	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Blood clotting problem	<input type="checkbox"/> Anemia