

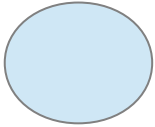
TOWN CENTER FOOT CLINIC

Podiatric physicians and surgeons specializing in the foot and ankle



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PATIENT REGISTRATION FORM

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

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 emergency contact _____

_____ Phone () _____

How did you find us? **(Dr./Patient Referral)** **(Internet)** **(Insurance)** _____

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)

ABOVE
BELOW

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 _____

MEDICAL HISTORY & INFORMATION Date of Birth _____

Please state current foot or ankle problem:

N/A **List any surgeries or major procedures you have had, including all body parts:**

Year	Surgery/procedure

N/A **List any major injuries or fractures you have had:**

Year	Injury/fracture

N/A **Check any known allergies:**

- | | | |
|--|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Anti-inflammatories (e.g. ibuprofen) | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Antibiotic: _____ | <input type="checkbox"/> Pain medication: _____ | <input type="checkbox"/> Anesthetic: _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Others: _____ | |

N/A **List current medications:**

Name	Dose	Frequency	What for

Do you take **aspirin** on a daily basis? Yes No

If you take any **herbal medications**, list them here: _____

N/A **Past Medical History--Check any known medical conditions:**

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Pregnancy (due date: _____) |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Diabetes <small>BS/A,C</small> | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> History of MRSA(Methicillin-resistant Staphylococcus aureus) | <input type="checkbox"/> kidney disease | |
| <input type="checkbox"/> Others: _____ | | |

SOCIAL HISTORY

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>Occupation</i>		
<i>Activity</i>	How often are you on your feet daily? _____ <input type="checkbox"/> 10% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 90%	

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

<input type="checkbox"/> N/A	Significant family health problems
Mother	
Father	
Siblings	
Grandmother (<i>Maternal</i>)	
Grandfather (<i>Maternal</i>)	
Grandmother (<i>Paternal</i>)	
Grandfather (<i>Paternal</i>)	

N/A **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

Height: _____ **Weight:** _____ **Shoe size:** _____

Primary care physician

Address

Phone () _____ Date of last visit to physician