TOWN CENTER FOOT CLINIC

Podiatric physicians and surgeons specializing in the foot and ankle

JOHN D. MOZENA, DPM, FACFAS
PAUL CLINT JONES, DPM

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 _____

for office use only:

Photo ID checked_____

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**:

☐ Penicillin	☐ Adhesive tape	☐ Latex
☐ Sulfa	☐ Anti-inflammatories (e.g. ibuprofen)	☐ Novocaine
☐ Antibiotic: _____	☐ Pain medication: _____	☐ Anesthetic: _____
☐ Iodine	☐ 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:**

☐ Arthritis	☐ Heart condition	☐ Pregnancy (due date:_____)
☐ Blood clots	☐ High blood pressure	☐ Respiratory problems
☐ Diabetes BS/A_1C	☐ Liver disease	☐ Stomach problems
☐ History of MRSA(Methicillin-resistant Staphylococcus aureus)		☐ kidney disease
☐ Others: _____		

SOCIAL HISTORY

Health Habits

Tobacco	Do you use tobacco? ☐ Yes ☐No
	If yes: Cigarettes – how many packs/day: For how many years:
Alcohol	Do you drink alcohol? ☐ Yes ☐No
	If yes, what form and how often?
Occupation	
Activity	How often are you on your feet daily? _____ ☐ 10%☐ 25%☐ 50%☐ 75%☐ 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

☐ **N/A**	Significant family health problems
Mother	
Father	
Siblings	
Grandmother *(Maternal)*	
Grandfather *(Maternal)*	
Grandmother *(Paternal)*	
Grandfather *(Paternal)*	

☐ **N/A** **<u>Review of systems</u> – check any symptoms that you are currently experiencing:**

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

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

Primary care physician

_____

Address

_____

Phone ( ) _____ Date of last visit to physician