Patient Registration Form

Last Name: ____________________ Legal First Name: ____________________ Middle: _________________

DOB: ____________ SS#: ____________ Sex: M / F Marital Status: Single / Married / Widow

Street Address: ____ (Apt #) __________________

City: _________________________ State: ____________ Zip: ____________________

Home Phone #: _______________ Cell Phone#: _______________ Work Phone #: _______________

May we leave a confidential message on your answering machine? Yes / No

Employer: ____________________________ Occupation: ___________________________

Email Address: ____

Ethnicity: _____________________ Race: _______________________ Primary Language: ______________

Emergency Contact Person: _________________ Relationship: ___________ Phone #: ________________

Whom may we thank for referring you to our offices? ____

Insurance Information Section

Primary Insurance: ______________________________ Secondary Insurance: ________________________

Subscriber of the Insurance: _______________________________ DOB of Subscriber: _____________

Phone number of the subscriber: ________________________

Patient relationship to the subscriber of insurance: ____________________

Milwaukee Foot Specialists will bill to your Insurance company on your behalf for your services. I authorize my insurance benefits to be paid directly to Milwaukee Foot Specialists. I understand that I am financially responsible for my balance. I also authorize Milwaukee Foot Specialists and / or the insurance company to release any information required to process my claims. This agreement will remain in effect until revoked by myself in writing. A copy of this document is considered as valid as the original.

The above information is true to the best of my knowledge. I will notify Milwaukee Foot Specialists of any changes.

Patient / Guardian Signature: __________________________ Date: _________________________

MILWAUKEE FOOT AND ANKLE SPECIALIST MILWAUKEEFOOT.COM

Patient Medical History

Patient Name:___________________________ Primary Care Physician: __________________

Phone # of PCP: ____________________ Date you last saw your PCP: _______________

Pharmacy: _________________________ Phone # of Pharmacy: ____________________

What is the foot or ankle condition you are being seen for today?
____

How long have you been suffering from your foot or ankle problem?______________________________

Is this a work related injury? Yes / No If yes please give the date of injury: _______________________

Height: __________ Weight: __________ Shoe Size: ___________

Hobbies:____

Do you smoke? Past Smoker? Yes / No How many packs per day? _______ How many years? ____

Do you drink alcohol? Yes / No How frequently? Rarely / Socially / Daily

Do you exercise? Yes / No Type of activity? _________________ Frequency? _____________

Are you Diabetic? Yes/ No If yes, do you take insulin? Yes/ No

Have you ever been treated for the following conditions? (Please circle all that apply)

High/Low Blood Pressure Liver Problems Pacemaker Blood Clots HIV

Heart Trouble Epilepsy Kidney Problems Hepatitis C Stroke Asthma

Family Medical History: Diabetes Cancer Blood Clots Stroke Heart attack

Please list **ALL** medications you currently take: ____
____

Please list **ANY** allergies to **ANY** medications: ____

Please list **ALL** major surgeries: ____

REVIEW OF SYMPTOMS

Have you experience any of the below symptoms? (Please circle all that apply)

General: unexpected weight loss/ weight gain, fever, chills, fatigue
Eyes: corrective lenses, blurred/double vision, eye pain, redness, watering
ENT: headache, difficulty swallowing, nosebleeds, ringing in ears, earaches
Cardiovascular: chest pain, palpitations, fainting, murmurs
Respiratory: Short of breath, sneezing, cough, tightness, inspiration pain, snoring
Gastrointestinal: heartburn, nausea, vomiting, constipation, diarrhea, blood/tarry stools
Genitourinary: frequency, urgency, difficult/painful urination, flank pain, bleeding
Musculoskeletal: joint pains, swelling, instability, stiffness, redness, deep muscle pain
Skin: skin changes, poor healing, rash, itching, redness
Neurologic: numbness/tingling, unsteady gait, dizziness, tremors, seizure
Psychiatric: nervousness, anxiety, depression, hallucinations
Hematologic: easy bleeding, bruising
Endocrine: excessive thirst or urination, heat/cold intolerable

Doctor Signature____ Date_________________