Patient Registration

Sierra Foot & Ankle

Patient Name: _____

Patient Information

Date _____ Social Security Number _____ Birthdate _____

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____ Extension _____

Occupation _____

Whom may we thank for referring you? _____ _____
First Name Last Name

In case of emergency who should we contact? _____ Phone _____

Patient's Doctors

Family/ Primary _____

Specialist _____

Other Podiatrist _____

Insurance Information

PRIMARY Insurance Company _____ Subscriber I.D. _____

SECONDARY Insurance Company _____ Subscriber I.D. _____

Assignment & Release:

Insurance Authorization & Assignment: I hereby authorize **Sierra Foot & Ankle** to furnish information to insurance carriers concerning my illness and treatments and to my referring physicians if so requested. I hereby assign to the physician all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize the use of this signature on all insurance submissions.

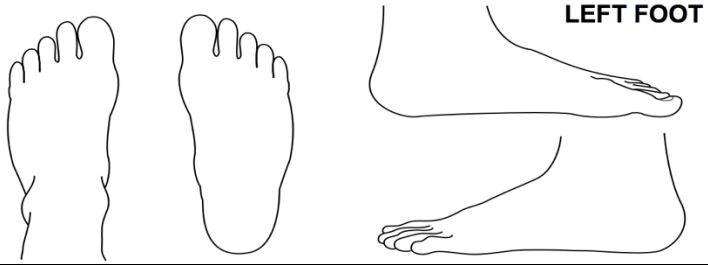
Signature of Responsible Party _____ Date _____
(Parent or Guardian if Minor)

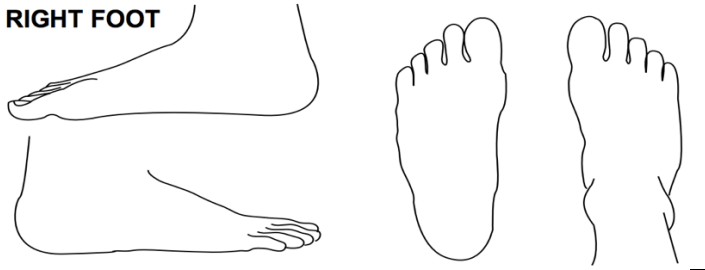
Tell me where it hurts

Please mark the location of your first problem or pain on the diagram below. Indicate the pain level with the appropriate face. Describe your problem below and its cause if you know it. Briefly describe your problem: _____

Previous medical treatments/remedies? _____

Is this problem work related? ☐ Y ☐ N Date of injury: _____ Date reported to employer: _____





Type of pain: ☐ Shooting ☐ Throbbing ☐ Aching ☐ Tenderness ☐ Sharp ☐ Burning ☐ Itching ☐ Dull ☐ Tingling ☐ Numbness

Happens: ☐ Walking≈ ☐ Not Walking

Started: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Type of pain: ☐ Shooting ☐ Throbbing ☐ Aching ☐ Tenderness ☐ Sharp ☐ Burning ☐ Itching ☐ Dull ☐ T ingling ☐ Numbness

Happens: ☐ Walking≈ ☐ Not Walking

Started: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Patient Name: _____

Issues in the past 6 months

CONSTITUTIONAL: ☐ **none**
☐ fever ☐ chills ☐ nausea ☐ vomiting
☐ weight gain ☐ weight loss ☐ fatigue

EYES: ☐ **none**
☐ eye disease ☐ impaired sight ☐ dry eyes ☐ double vision

HEAD/EARS/NOSE/THROAT: ☐ **none**
☐ headache ☐ sinus problems ☐ speech difficulty
☐ ear ringing ☐ swallowing difficulty ☐ hearing loss ☐ vertigo

CARDIOVASCULAR: ☐ **none**
☐ chest pain ☐ rapid heart rate ☐ heart murmur
☐ leg pain with walking ☐ leg pain @ night sleeping
☐ cold feet

RESPIRATORY: ☐ **none**
☐ shortness of breath ☐ rapid breathing
☐ chronic/persistent cough ☐ sleep apnea

GASTROINTESTINAL: ☐ **none**
☐ diarrhea ☐ constipation ☐ black stool
☐ stomach ulcers ☐ liver problems

GENITOURINARY: ☐ **none**
☐ painful urination ☐ difficulty urinating
☐ urinary incontinence ☐ blood in urine

MUSCULOSKELETAL: ☐ **none**
☐ muscle weakness ☐ chronic back pain
☐ sciatica ☐ joint pain ☐ joint swelling

INTEGUMENTARY: ☐ **none**
☐ acute skin rash ☐ itching ☐ skin cancers
☐ history of skin ulcers ☐ nail irregularities

NEUROLOGICAL: ☐ **none**
☐ numbness ☐ paralysis ☐ memory loss ☐ confusion

PSYCHIATRIC: ☐ **none**
☐ claustrophobia ☐ anxiety ☐ insomnia
☐ agitation ☐ hallucination

ENDOCRINE: ☐ **none**
☐ heat intolerance ☐ cold intolerance ☐ frequent urination
☐ always thirsty

HEMATOLOGIC: ☐ **none**
☐ bruise easily ☐ use of anticoagulant

ALLERGIC/IMMUNOLOGIC: ☐ **none**
☐ food allergy ☐ organ transplant

Foot History

Shoe Size	Weight:	Height:

☐ Corns/Calluses ☐ Warts ☐ Athlete's Foot
☐ Leg/Foot Ulcers ☐ Fungal Nails ☐ Ingrown toenails
☐ Broken Foot Bones ☐ Neuroma ☐ Foot Numbness
☐ Hammer/Mallet toes ☐ Broken Ankle ☐ Ankle Sprain
☐ Cramps in legs/toes ☐ Bunions ☐ Flat Feet
☐ Lower Back Pain ☐ Arch Pain ☐ High Arch Feet
☐ Gait (walking) problems ☐ Knee Pain ☐ Heel Pain
☐ Childhood foot problems ☐ In-Toeing ☐ Toe Walking
☐ Rash ☐ **None of These**

Do you previously/Do you now wear:
☐ Shoe Inserts: ☐ Still Use them ☐ They Still Help
☐ Orthotics: ☐ Still Use them ☐ They Still Help

The orthotics were obtained from: ☐ Another podiatrist
☐ An Orthopedist ☐ Physical Therapist
☐ Chiropractor ☐ Other

Are your first steps out of bed painful ☐Yes ☐ No
then subside? ☐Yes ☐ No

Does foot pain limit your desired activities? ☐Yes ☐ No

Medical History

☐ **No past or active medical conditions reported**.
☐ Anemia ☐ Anxiety ☐ Arthritis
☐ Asthma ☐ Bleeding Disorder ☐ Cancer
☐ COPD: ☐ Emphysema ☐ Chronic Bronchitis
☐ Stroke: Affected: _____
☐ Dementia ☐ Depression ☐ Osteoporosis/Osteopenia
☐ Diabetes with ☐ kidney probs ☐ neuropathy ☐ eye probs
☐ Fibromyalgia ☐ Gout ☐ Heart Disease
☐ Hyperlipidemia ☐ Hyperthyroid ☐ Hypothyroid
☐ Liver problems ☐ Neuropathy ☐ Hep C ☐ Obesity
☐ Parkinson's ☐ Renal probs ☐ Vascular Disease
☐ High blood pressure ☐ Macular degeneration

Social History

Tobacco use ☐ none ☐ occasional ☐ daily ☐ Quit
_____packs per day for _____ years
Alcohol use ☐ none ☐ occasional ☐ daily
Caffeine use ☐ none ☐ occasional ☐ daily
Recreational Drugs ☐ none ☐ occasional ☐ daily
Living arrangement ☐ alone ☐ w/spouse ☐ w/children
☐ w/pets ☐ w/significant other ☐ w/roommate
☐ at assisted living facility
Current Occupation _____
Amount of Time per day on feet at work
Recreational Activities ☐ running ☐ walking ☐ hiking ☐ golf
☐ lifting weights ☐ cycling ☐ dance ☐ swimming
☐ Other _____
Activity Level ☐ low ☐ moderate ☐ strenuous

Surgical History

Surgery	**Year**

Medications

Or attach a list of ALL your medications

Medication	Dosage	Frequency

Family History

List the relationship to you, of family who have had…

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

Allergies / Drug Reactions

☐ **No Known Drug Allergies**
☐ Sulfa ☐ Iodine ☐ Aspirin
☐ Other Antibiotics ☐ Morphine ☐ Codeine ☐ Latex
☐ NSAIDs (Advil/Aleve/Motrin) ☐ Penicillin
☐ Local Anesthetic (Lidocaine/Novocaine) ☐ Adhesives
☐ Other: _____