INSTEP FOOT & ANKLE
Specializing In Heel Pain

PATIENT REGISTRATION FORM

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

Which doctor are you seeing today? ☐ Dr. Jones

Patient name ______________________ Social security #__________

Birth date _____ /_____ /_______ Age _____ ☐ Male ☐ Female Marital status __________

Mailing address ______________________ Phone ( )__________

City ____________ State _____ ZIP _______ Cell phone ( ) __________

Email address______________________Driver's License #__________

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 ( )__________

How did you hear of our office?______________________

Who is the financial responsible party? circle Self / For Minor ______________________

Soc. #_____ - _____ - _______ DOB______________________

Employer______________________ Phone ( )__________

Address______________________

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 ______________________

www.instepfootandankle.com

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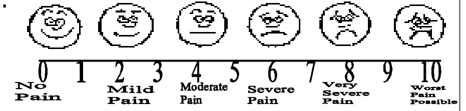
* 740 McKinley Avenue * Kellogg, ID * (866) 926-5518

FAX (509) 922-9892

MEDICAL HISTORY & INFORMATION

Paul Clint Jones, D.P.M.

Please state current foot or ankle problem: when started, treatments, etc.



Primary care physician

____

Address

____

Phone (   )_______________ Date of last visit to physician___________________

List current medications: ☐ **NONE**

Name	Dose	Frequency	What for

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

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

Check any known allergies: ☐ **NONE**

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

List any surgeries or major procedures you have had: ☐ **NONE**

Year	Surgery/procedure	Complications?

List any major injuries or fractures you have had: ☐ **NONE**

Year	Injury/fracture

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?
Activity	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 *(Maternal)*	
Grandfather *(Maternal)*	
Grandmother *(Paternal)*	
Grandfather *(Paternal)*	

Review of systems --known medical conditions: ☐ **NONE**

☐ Arthritis	☐ Heart condition	☐ Pregnancy (due date:____________)
☐ Blood clots	☐ High blood pressure	☐ Respiratory problems
☐ Diabetes	☐ Liver or kidney disease	☐ Stomach problems
☐ Others: ____________________		

– check any symptoms you are currently experiencing: ☐ **NONE**

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
Hemotological	☐ Easy bruising	☐ Blood clotting problem	☐ Anemia

Height: __________________ **Weight**: ____________________ **Shoe size**: ____ _