



**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 \_\_\_\_\_

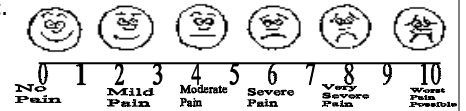
Date \_\_\_\_\_

# 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**

<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: _____	

**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



## Social History

Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>If yes:</b> Cigarettes – how many packs/day: _____ For how many years: _____
Alcohol/Drugs	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Use any Recreational Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>If yes,</b> what form and how often?
Activity	What <b>percent</b> of the day (i.e. the time you are awake) are you on your feet? _____%
Occupation	

**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)	

### SYSTEMS REVIEW --known medical conditions: NONE

<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 BS <input checked="" type="checkbox"/>	<input type="checkbox"/> Liver or kidney disease	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Others: _____

### – check any **SYSTEM SYMPTOMS** you are currently experiencing: NONE

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

## MEDICAL HISTORY & INFORMATION

PAUL CLINT JONES, D.P.M.

