Date _____

Foot Specialist Associates P.C.

Chart # _____

Patient Registration Form

Identifying Information

Name _____ Date of Birth ___/____/____

Race _____ Ethnicity _____

Preferred Language _____

Pharmacy & Doctor

Pharmacy Name _____ Phone ( ) _____

Pharmacy Address _____

Primary Care Physician _____ Phone ( ) _____

Primary Care Physician Address _____

Primary Care Physician – Date Last Seen ____/_____/_____

Referring Physician _____ Phone ( ) _____

Referring Physician Address _____

Referring Physician – Date Last Seen ____/_____/_____

Privacy Information Preferences

Do you want to be exempt from public reporting?	☐ Yes ☐ No
Can we call the phone number on file?	☐ Yes ☐ No
Will you allow us to send emails of reminders and newsletters? If yes, enter email address: _____	☐ Yes ☐ No
Can we send mail to the address on file?	☐ Yes ☐ No
Can we call the phone number on file?	☐ Yes ☐ No
Can we leave a voicemail on machine?	☐ Yes ☐ No
Who can we leave messages with? ☐ Spouse ☐ Son ☐ Daughter Other: _____	

Smoking

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Never Smoked

☐ Former Smoker ☐ I Decline to State Quit, When? ____ / ____ / _____

Vital Signs

Blood Pressure _____ / _____ Height: _____ Weight: _____

Current Medications

☐ No Known Medications

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Please use the back of this form if more room is needed. More info on back ☐

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: ____/____/_____