



NEW PATIENT REGISTRATION FORM

Patient Information

Patient Last Name: _____ Patient Legal First Name: _____ Preferred Name: _____ Middle Initial: _____

Patient Date of Birth: __/__/____ Patient Social Security #: _____ Gender: M / F Marital Status: Single Married Other

Primary Language: English Other _____ Ethnicity : Not Specified Hispanic/Latino Not Hispanic/Latino

Race: Not specified American Indian Asian Alaska Native Black/African American Native Hawaiian White

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Email: _____

I understand that the above information will be used to contact me regarding appointments, treatments and billing matters. I agree to phone, text, and email communications from this office, with the understanding that I can opt out of text (msg & data rates may apply) and emails if I so choose.

Street Address (No PO Box): _____ City: _____ State: _____ Zip Code: _____

Pharmacy: _____ City: _____ Crossroads/Zip Code: _____

Primary Care Doctor: _____ City: _____ Date Last Seen: _____ Office Phone #: (____) _____ - _____

Emergency Contact Name: _____ Relationship: _____ Best Phone #: (____) _____ - _____

Primary Insurance Carrier: _____ Name of Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance Carrier: _____ Name of Policy Holder: _____ Policy Holder DOB: _____

Auto or Work Comp? YES / NO If yes, Date: _____ Claim #: _____ Claim Rep Name/Phone #: _____

Medicare Only: Are you enrolled in Hospice? YES / NO Do you receive home health care? YES / NO Do you live in a nursing home? YES / NO

HOW DID YOU HEAR ABOUT OUR PRACTICE? Family/Friend: _____ Google

Facebook Instagram Event Insurance Website Signage Dr: _____ Other: _____

Privacy Information

Where may we contact/leave you message(s): **HOME:** Yes No **CELL:** Yes No

Name of person(s) who can have access to your records/PHI or pick items up for you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____



Current Medical History

Patient Last Name: _____ Patient Legal First Name: _____

Patient Shoe Size: _____ Weight: _____ Height: _____ Do you exercise regularly? Yes No If yes, how often?

Are you Diabetic? YES / NO If yes, Diabetic Care Dr: _____ Date Last Seen: _____ Last A1C: _____ Year Diagnosed: _____

Allergies: None Adhesive/Tape Anesthetics Aspirin Blood Thinners Codeine Dairy Demerol Eggs Erythromycin IV contrast
 Iodine Latex Penicillin Seafood Sulfa Other(s): _____

List all Hospitalizations (Reason and Date): _____

List all Surgeries (Type and Date): _____

Current Medications

Medication List can be copied and attached separately if available - You do NOT have to rewrite medications!

None

Medication 1: _____ Dosage: _____ Medication 2: _____ Dosage: _____

Medication 3: _____ Dosage: _____ Medication 4: _____ Dosage: _____

Medication 5: _____ Dosage: _____ Medication 6: _____ Dosage: _____

Medication 7: _____ Dosage: _____ Medication 8: _____ Dosage: _____

Review of Systems

Check all of the following problems below that apply to you on a regular basis

Constitutional: Chills Fatigue Fever Weakness

Head: Dizziness Fainting Headaches

Neurological: Numbness Strokes Tingling Tremors

Skin: Dryness Eczema Lumps Mole Changes

Endocrine: Thyroid Issues Weight Loss Weight Gain

Psychiatric: Depression Anxiety Insomnia

Gastrointestinal: Constipation Diarrhea Heartburn Hepatitis Liver Disease Nausea

Hematologic/Lymph: Anemia Blood Clots Chemotherapy Slow Healing Cuts Swollen Glands Transfusion Reaction

Musculoskeletal: Arthritis Back Problems Joint Implants Joint Pain/Stiffness Muscle Cramps/Stiffness Paralysis Restricted Motion

Cardiovascular: Chest Pain Cramps Cool Extremities Hair loss on legs High Blood Pressure Heart Attack Palpitations

Leg/Foot Ulcers Shortness of Breath Varicose Veins Vascular Grafts Vascular Stents

Past Medical History

Mark "None" if the history below does NOT apply to you

None

Chronic Back Pain

Heart Attack

Parkinson's Disease

AIDS/HIV

Chemotherapy

Hepatitis Type _____

Rheumatoid Arthritis/Autoimmune

Abnormal Heart Beat

Circulation Problems

High Cholesterol

Seizures

Anxiety

Dementia

High Blood Pressure

Stroke

Asthma

Depression

Kidney Disease

Thyroid Disorder

Bleeding Disorder

Diabetes

Liver Disease

Ulcers/Sores

Blood Clot

Gastric Reflux

Multiple Sclerosis

Other: _____

CAD

Glaucoma

Neuropathy



Brighton FOOT & ANKLE

- Cancer (Type) _____ Gout Osteoarthritis

Are you currently pregnant or nursing? YES / NO

Social History

Employment Status: Full-Time Part-Time Retired Unemployed Student Occupation: _____ Employer: _____

Smoking History: Non-Smoker Current Smoker - Amount/day: _____ Former Smoker - Years of cessation: _____
 Marijuana - Amount/day: _____

Do you drink alcohol? YES / NO If yes, socially occasionally heavily Other Drug Use?: _____

Family History

Place an "X" on all applicable lines

	Father	Mother	Both
Diabetes	_____	_____	_____
Cardiovascular Disease: _____	_____	_____	_____
Cancer: _____	_____	_____	_____
Bleeding Disorders	_____	_____	_____
Bunion	_____	_____	_____
Hammertoe	_____	_____	_____
Flat Feet	_____	_____	_____
High Arch Feet	_____	_____	_____
Other: _____	_____	_____	_____

Current Foot and Ankle Conditions

Check all of the following problems below that apply to you

Musculoskeletal:

- Ankle Sprain Arch Pain Broken Foot/Ankle Bunion(s) Childhood Foot Problems Flat Feet
 Gait (Walking) Problem Gout Hammertoe(s) Heel Pain High Arch Feet In-Toeing
 Neuroma Orthotic Use Shoe Insert Use Toe Walking

Vascular:

- Lower Extremity Stent(s) Raynaud's Disease Varicose Veins

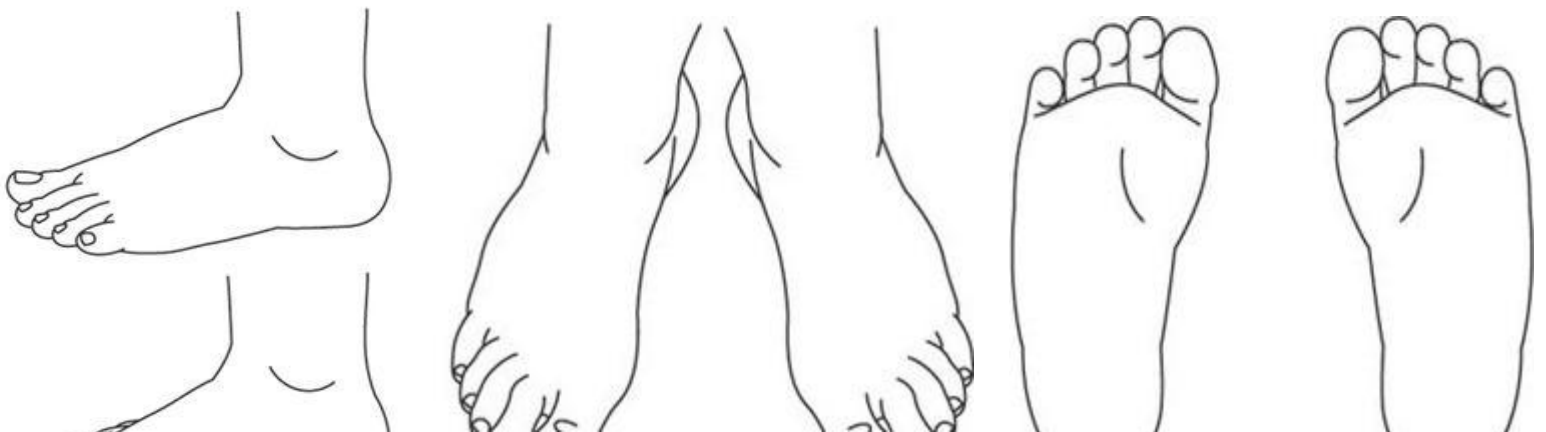
Skin:

- Athlete's Foot Fungal Nails Ingrown Nails Keloid Scar Wart(s) Ulcer(s)

Neurological:

- Charcot Neuropathy Burning Unsteady Gait

Please indicate the affected area on the diagram below:





ATTEST

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Brighton Foot and Ankle immediately of any changes to the above information and annually upon the office's request. I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy Version 1.22, Authorization from Patient or Legal Representative version 1.22, and Notification of Office Policies and Procedures version 1.22 (available in our waiting room and/or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "Notifications of Office Policies and Procedures", "HIPAA Policy Notice of Privacy Practices" and "Authorization from Patient or Legal Representative."

Print Patient's Name or Legal Representative

Signature

Relationship to Patient

Date

INSURANCE PATIENTS ONLY

Please initial **ONE** and sign below

_____ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility- even if I have secondary insurance.

_____ I understand that my insurance is Out-of-Network and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

_____ I understand that even though I have insurance I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance will NOT be billed and fees for service rendered must be paid today.

Signature

Date

NO INSURANCE/CASH PATIENTS ONLY

Please initial and sign below if you have no insurance

_____ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered.

Signature

Date