

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. **Please fill in all blanks, if information does not apply, please write "N/A".**

Patient Name	Date of Birth	Sex	Age	
Parent If Patient is a Minor				
Patient's Social Security Number	Driver's License No.			
Home Address	City	State	Zip	
Mailing Address If Different	City	State	Zip	
Home Telephone	Work Telephone			
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer			
Family Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
INSURANCE INFORMATION:				
Insurance Company	Telephone			
Claim Address	City	State	Zip	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security No.		
Insurance ID No.	Insurance Group No.			
Secondary Insurance	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security No.		
Were You Injured on the Job?	YES	NO	Have You Informed Your Employer?	
			YES	NO
Date of Original Injury				
Worker's Compensation Carrier Name	Address			

PAYMENT POLICY:

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

AUTHORIZATION OF PAYMENT:

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

Signed _____ Date _____

(Patient or Patient's Parent or Guardian if Minor)

San Antonio Podiatry Associates, PC Medical History

thank you for choosing San Antonio Podiatry Associates to care for your foot care needs. Please take a moment to complete this Medical History form. Thank You!

Name: _____

D.O.B. ____/____/____

Please describe your present foot problems: _____

How long have you had this problem? ____ Days, ____ Weeks, ____ Months, ____ Years

Have you had previous treatment for this problem? ____ Yes ____ No

If yes, by whom and when: _____

Family Physician: _____

Last Visit Date: ____/____/____

Please check *Yes* or *No* to indicate if you have any of the following:

	Y	N		Y	N		Y	N		Y	N
Aids / HIV			Circulatory problems			Hepatitis			Radiation treatment		
Allergies to anesthetics			Depression			High blood pressure			Respiratory disease		
Anemia			Diabetes			Jaundice			Rheumatic fever		
Angina			Dialysis			Kidney problems			Sinus problems		
Arthritis			Ear problems			Liver disease			Skin cancer		
Artificial heart valves			Epilepsy			Low blood pressure			Stroke		
Artificial joints			Eye problems			Nervous problems			Swollen neck glands		
Asthma			Fainting			Neuropathy			Thyroid problems		
Back problems			Glaucoma			Osteoporosis			Tuberculosis		
Bleeding disorders			Gout			Phlebitis			Ulcers		
Cancer, _____			Heart attack			Pneumonia			Varicose veins		
Cataracts			Heart disease			Prostate problems			Venereal disease		
Chemical dependency			Heart surgery			Psoriasis			Other, _____		
Chronic diarrhea			Hemophilia			Psychiatric care			Other, _____		

Previous Surgeries *(Please list any prior surgeries and dates)*

Previous Hospitalizations *(Please list reason/dates for hospitalizations other than for above surgeries)*

Medications *(Please list all current medications including over-the-counter medications and oral contraceptives)*

Family History *(Please list any significant family history)*

(Please complete backside of form)

