BRIAN R. FRADETTE, D.P.M., F.A.C.F.A.S.

Medical and Surgical Treatment of the Foot and Ankle

PATIENT REGISTRATION FORM

Patient _____ Emergency Contact Name _____
Last First MI Last First

Address _____ Phone _____

_____ Primary Care Physician _____

Home Phone _____ PCP's Address _____

Work Phone _____ Cell _____ _____

Birth Date ____/____/____ Who referred you to our office? _____

Sex: M F Marital Status _____ Has any member of your family been a patient in our office? Yes No

Social Security Number _____ If yes, who _____

Insurance Information:

Primary Insurance Company Name _____ Effective Date _____

ID/Member Number _____ Group Number _____

Subscriber's Name _____ Date of Birth ____/____/____ Sex M F

Subscriber's Social Security Number _____ Relationship to Patient Self Spouse Parent Child

Subscriber Employer _____ Phone Number _____

Employer's Address _____
Street City State Zip Code

Injury Information: ☐ Work Related ☐ Auto Related Claim Number _____ Date of Injury _____

I authorize the practice to submit claims to my insurance carrier and all unpaid balances will be the responsibility of the undersigned. This includes any fees associated with the collection of said balances. (i.e., Collection Agency Fees, Attorney/Court Fees. etc.) I authorize the release of any medical information necessary to process the claim. I also hereby authorize release and assign benefits otherwise payable to the practice. Obtaining referral authorization for your visit is the responsibility of the patient or responsible party.

Signature _____ **Date** _____

I acknowledge receipt of the privacy notice for this practice.

Signature _____ **Date** _____

MEDICAL INFORMATION

This information is important for our records and your health.

Please describe your foot / ankle problem(s) _____

_____

_____

_____

Approximately, how long has it been bothering you? _____ Days _____Weeks _____Years

Any past foot or ankle problems? _____

_____

_____

Past foot / ankle care or surgery?_____

_____

When? _____

Height _____ Weight _____ Shoe Size _____

Previous hospitalizations? If yes, for what reason _____

_____

Place of employment _____

Employment ☐ Sit mostly ☐ Stand mostly ☐ Walk and Stand

What medications do you take? 1 _____ 2 _____

3 _____ 4 _____ 5 _____

6 _____ 7 _____ 8 _____

Name of your Pharmacy or Drug Store _____ Phone number_____

Family History

Mother ☐ Living ☐ Deceased Cause of Death _____

Father ☐ Living ☐ Deceased Cause of Death _____

Brother ☐ Living ☐ Deceased Cause of Death _____

Sister ☐ Living ☐ Deceased Cause of Death _____

Is there a family (blood relative) history of: ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ Bunions ☐ Hammer toes

☐ Flat feet ☐ Circulation Problems ☐ Arthritis ☐ Other _____

GENERAL HEALTH INFORMATION

Are you allergic or sensitive to any antibiotics or other medications? (ie: Penicillin, Novacaine, Aspirin) _____

_____

Any problems with anti-inflammatory drugs (Ibuprofen, Advil, Motrin, etc...) ?

☐ Yes ☐ No; if yes please describe _____

Do you have Diabetes? ☐ Yes ☐ No Number of Years _____ If yes, do you take insulin? ☐ Yes ☐ No

Do you have any diabetic neuropathy ***(increased or decreased pain sensation)*** **in the lower legs/feet?** ☐ Yes ☐ No

Have you had any serious illness? _____

Have you had any major surgeries? _____

_____

Your Physician's name _____

Are you presently under a physician's care? ☐ Yes ☐ No If yes, for what condition _____

_____

Approximate date you last saw this physician _____ May we contact your physician about your health? ☐ Yes ☐ No

Check with an **X** any of the following condition(s) you have, or have had a problem with:

☐ Heart	☐ Asthma	☐ Tuberculosis	☐ Liver
☐ High Blood Pressure	☐ Stomach Ulcers	☐ Rheumatic Fever	☐ Intestines
☐ Circulation	☐ Frequent Infections	☐ Excessive Bleeding	☐ Arthritis
☐ Anemia	☐ Thick Scars	☐ Kidney	☐ Skin
☐ Nerve Disorder	☐ Stroke	☐ Lung	☐ Gout
☐ AIDS/HIV Positive			

Women: Are you pregnant? ☐ Yes ☐ No If yes, Due date _____

Do you have any artificial joints? ☐ Hip ☐ Knee ☐ Other _____

Do you have a heart valve implant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, _____Number of packs per day.

Do you drink alcohol? ☐ Yes ☐ No

If yes, ☐ Light, 1-2 per week ☐ Moderate, 1-2 per day ☐ Heavy, more than 2 daily

Thank you for filling out this information!