



# PODIATRIC REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

### INSTRUCTIONS:

You can type your information right into this form to complete it and press the Print Form button above

OR

press the Print Form button now for a blank form and complete the form in by writing in the information.

Please bring the completed form with you to your appointment.

THANK YOU!

Patient Employer or School \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer or School Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, PLEASE CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## INSURANCE

Who is responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

### INSURANCE ASSIGNMENT AND RELEASE

Name of Insurance Company(ies)

I certify that I have insurance coverage with \_\_\_\_\_ and assign directly to **DR. JAVAN BASS, D.P.M.**, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **DR. JAVAN BASS, D.P.M.** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Athletic activities in which you participate (please list and indicate frequency)

Have you ever been to a Podiatrist before?

Yes  No

If yes, please list Name \_\_\_\_\_

Last visit \_\_\_\_\_

Is there any personal or family history of diabetes?

Yes  No

Occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_ Years smoked \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Corns and Calluses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cramps or Numbness in Feet or Legs.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foot or Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling Ankles or Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies or Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Surgeries you have had

Hospitalization other than for the surgeries listed

Family Physician \_\_\_\_\_

Last visit \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

Yes  No

If yes, please explain

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins

Dosage

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name(s) \_\_\_\_\_ Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

## ALLERGIES

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

## TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_