Bay Area Foot Care
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ MI ____

Date of Birth _____

SSN _____

Address _____

City _____

State _____Zip_____

Telephone (_____) _____

E-mail:_____

Primary Physician_____

Phone# _____

Referring Physician_____

Phone#_____

☐ **Male** ☐ **Female** ☐ **Non Binary**

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

☐ **White** ☐ **American Indian / Alaska Native** ☐ **Asian**

☐ **Black or African American** ☐ **Native Hawaiian**

☐ **Hispanic Latino** ☐ **Other** ☐ **Veteran**

Occupation _____

Employer _____

Address_____

_____

Check Preferred Method

☐ Work Phone (____) _____Ext_____

☐ Cell Phone (____) _____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

◯ Self ◯ Spouse ◯ Dependent

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse ☐ Dependent

PHARMACY INFORMATION

Pharmacy Name_____

Phone #: _____Fax #:_____

Address_____

City_____ State_____

Zip_____

EMERGENCY CONTACT (If other than Spouse)

Name:_____

Relationship: _____

Telephone (____) _____

Guarantor Information: Complete if different from Patient

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____) _____

DOB _____/_____/_____

Employer_____

Address_____

Work Phone (____) _____Ext_____

PATIENT NAME_____ DATE OF BIRTH_____/_____/_____

Is your treatment today due to:

…….a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated Yes ☐ No ☐

…….a motor vehicle accident ☐ Yes ☐ No Accident Date_____

…….a an accident/ liability case ☐ Yes ☐ No Accident Date_____

Whom may we thank for sending you to our office?

☐ Doctor_____

☐ Patient_____

☐ Social Media_____

☐ Insurance Provider List ☐ Health Fair

☐ Passed by Location ☐ Internet Search

☐ Other_____

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____ Date_____

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. **I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.**

Signature _____ Date _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits, be made on my behalf to **Bay Area Foot Care** for any services furnished to me by the listed provider/supplier. 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, and their agents any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)	**PROVIDER: Name**
	Alexander Reyzelman, DPM Inc. Bay Area Foot Care, Inc
PATIENT'S SIGNATURE	

Patient Name: _____ **DOB:** _____ **Date:**_____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

   _____

2. **When did pain/discomfort begin (date):** _____
3. **What makes the pain/discomfort better?** _____
4. **Was this a result of a personal injury?** ☐ No ☐ Yes Injury Date_____
5. **Was this a result of a car accident?** ☐ No ☐ Yes Injury Date _____
6. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No
7. **Allergies:** (Describe reaction) ☐ **NONE**

   ☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
   ☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
   ☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
   ☐ NSAIDS_____ ☐ Other _____

8. **List all medications/herbs/vitamins:** ☐ **NONE**

Meds	Dose	Start Date	Meds	Dose	Start Date

9. **Family History: (List relationship of family member(s) who have had these problems):**

   ☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____
   ☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
   ☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
   ☐ Other family History:_____

10. **Shoe size:** _____
11. **Social History:**

    Tobacco Use (Check one)
    ☐ Never a smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker

    Alcohol Use (Check one)
    ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

    Drug use (recreational, IV)
    ☐ Please specify_____

    Exercise habits (Check one)
    ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

12. **Are you currently pregnant?** ☐ No ☐ Yes _____

13. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____ Surgery / Date: _____

Surgery / Date: _____ Surgery / Date: _____

Surgery / Date: _____ Surgery / Date: _____

14. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease (Dialysis Yes/No)	☐ Liver Disease
☐ Bleeding Disorders	☐ Heart Failure	☐ Lung/Respiratory Disorders	☐ Arthritis of _____
☐ Cancer of _____	☐ Heart Disease	☐ Tuberculosis (Year:_____)	☐ Rheumatoid Arthritis
☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Pacemaker (Year:_____)	☐ Stroke (Year:_____)
☐ Osteoporosis	☐ HIV / AIDS	☐ High Blood Pressure	☐ HYPOthyroidism
☐ Artificial Joints	☐ Raynaud's Disease	☐ Heart Attack/MI (Year:_____)	☐ HYPERthyroidism
☐ Organ Transplant	☐ Asthma	☐ Coronary Artery Disease (CAD)	☐ Prostate Disorders
☐ Nerve Disorders	☐ Back Pain	☐ Blood Clot Lung (PE)	☐ Hepatitis A
☐ Diabetes Type 1 (Year: _____)	☐ Fibromyalgia	☐ Blood Clot Lung (DVT)	☐ Hepatitis B
☐ Chronic Obstructive Pulmonary Disease (COPD)		☐ Diabetes Type 2 (Year: _____)	☐ Hepatitis C
		☐ Other: _____	

15. **<u>Other information you would like the doctor to know:</u>**

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	