# PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____
Date of Birth: ____/____/____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _____
(Street) (City/State/Zip)
Home Phone: (_____) _____-_____ E-mail Address: _____
Would you be interested in having communications sent to you via your e-mail address? (examples: appointment reminders, administrative updates and health bulletins) Yes No
Employer Name: _____ Employer Phone Number: (_____) _____
Employer Address: _____
(Street) (City/State/Zip)
Primary Care Physician: _____ Copay Amount $_____
(Name)
How did you hear about our Practice? _____

**Person responsible for bill or parent (Complete only if different from patient)**
Guarantor Name: _____ Social Security Number: _____ - _____ - _____
Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: ____/____/____
Address: _____ Phone Number: _____
Employer Name: _____ Employer Phone Number: (___) _____
Employer Address: _____
(Street) (City/Street)

**Who to call for an emergency:**
Name: _____ Address: _____
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

**FIRST INSURANCE INFORMATION**
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

**SECOND INSURANCE INFORMATION**
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

**THIRD INSURANCE INFORMATION**
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

***IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y____ N____***
***IF YES, PLEASE NOTIFY THE RECEPTIONIST***

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Northeast Health. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
Signature: _____ Date: _____
PCN-100 (Rev.10/30/00)

CERTIFIED
FOOT & ANKLE
SPECIALISTS, P.L.

Kyle J. Kinmon, MS, DPM
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Diplomate, *American Board of Podiatric Surgery*
Board Certified, *Foot Surgery*
Board Certified, *Reconstructive Rearfoot & AnkleSurgery*

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Donald R. Powell, DPM

# MEDICAL HISTORY

Patient Name: _____ Age: _____

Primary Care/Family Doctor Name: _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Have you ever had or been treated for:

| | | | | |
|---|---|---|---|---|
| ☐ knee pain | ☐ heel pain | ☐ ankle injury | ☐ arch pain | ☐ low back pain |
| ☐ bunions | ☐ broken foot bone(s) | ☐ high arch feet | ☐ corns | ☐ callouses |
| ☐ foot/nail fungus | ☐ childhood foot problems | ☐ hammertoes | ☐ rash | ☐ ingrown nails |
| | | ☐ flat feet | ☐ neuroma | |

What percentage of the time that you are awake are you on your feet? (*circle one*)
20% 40% 60% 80% 100%

List any sports or activities that you are involved in: _____

Do your feet hurt at night?.....☐ Yes ☐ No
Do you have any difficulty walking?.....☐ Yes ☐ No
Do you get leg cramps?.....☐ Yes ☐ No
Any pain in calves or buttocks when walking?.....☐ Yes ☐ No
Does rest relieve the pain?.....☐ Yes ☐ No ☐ N/A

Do you have *or* have you ever been treated for:

| | | | | |
|---|---|---|---|---|
| ☐ Epilepsy | ☐ Nerve Disorder | ☐ Cancer | ☐ Depression | ☐ Glaucoma |
| ☐ Stomach Ulcer | ☐ Psychiatric Disorder | ☐ Rheumatic Fever | ☐ Scarlet Fever | ☐ Stroke |
| ☐ Heart Attack | ☐ High Blood Pressure | ☐ Heart Disease | ☐ Phlebitis | ☐ Trauma |
| ☐ Diabetes | ☐ Hepatitis | ☐ Liver Disease | ☐ Anemia | ☐ Gout |
| ☐ Kidney Disease | ☐ Asthma | ☐ Lung Disease | ☐ Tumors | ☐ Cataracts |
| ☐ Arthritis | ☐ Alzheimer's Disease | ☐ Blood Clots | ☐ _____ | |

Do you have vascular grafts?.....☐ Yes ☐ No
Do you have replacement heart valves?.....☐ Yes ☐ No
Have you had any other serious illness?.....☐ Yes ☐ No
Do you have joint implants?.....☐ Yes ☐ No
Are you now under active chemotherapy?.☐ Yes ☐ No
Have you ever been hospitalized or needed medical care at home?.....☐ Yes ☐ No
*Please explain:* _____

Have you ever had any of the following operations:

| | | | | | |
|---|---|---|---|---|---|
| Tonsils..... | ☐ Yes | ☐ No | Year_____ | Appendectomy..... | ☐ Yes ☐ No Year_____ |
| Gallbladder..... | ☐ Yes | ☐ No | Year_____ | Hysterectomy..... | ☐ Yes ☐ No Year_____ |
| Hemorrhoids..... | ☐ Yes | ☐ No | Year_____ | Heart Surgery..... | ☐ Yes ☐ No Year_____ |
| Varicose Veins.... | ☐ Yes | ☐ No | Year_____ | Hip or Knee Surgery..... | ☐ Yes ☐ No Year_____ |
| Plastic Surgery.... | ☐ Yes | ☐ No | Year _____ | Foot of Ankle Surgery.... | ☐ Yes ☐ No Year_____ |

Have you had any other operations?....☐ Yes ☐ No *explain:* _____

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List family members *(son, daughter, father, mother, grandparents, brother, sister, etc.)* who have had:

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

Are you slow to heal after cuts?..... ☐ Yes ☐ No Any abnormal bruising or bleeding?..... ☐ Yes ☐ No
Are you taking insulin?..... ☐ Yes ☐ No Are you taking a blood thinner medication? ☐ Yes ☐ No

| Medications I take: | Strength? | For What Problem? | How Long? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently pregnant?..... ☐ Yes ☐ No Are you planning on becoming pregnant?... ☐ Yes ☐ No

Do you smoke now?..... ☐ Yes ☐ No Number of packs per day _____ for _____ years
Did you ever smoke?..... ☐ Yes ☐ No Number of packs per day _____ for _____ years
If you quit, when did you do so? _____
Do you drink alcoholic beverages? *(circle one)* Never Rarely Moderately Daily Quit
Do you use recreational drugs? *(circle one)* Never Rarely Moderately Daily Quit

## PATIENT HISTORY

**CHIEF COMPLAINT:** (Onset, Course, Duration, Quality, Location)

_____

_____

_____

_____

**ALLERGIES:** ASA Codeine Penicillin Other: _____

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## REVIEW OF SYSTEMS

Please circle or list problems in each body system.

**Constitutional:** fever weight gain weight loss appetite change night sweats fatigue chills

**Eyes:** blurry double vision vision loss tearing redness pain sensitivity to light glaucoma

**Ears, Nose, Mouth, Throat:** hearing loss ringing in ears ear pain nasal congestion nasal drainage nosebleeds mouth/throat irritation tooth problem

**Cardiovascular:** chest pain/pressure heart racing palpitations sweating leg swelling high/low blood pressure

**Pulmonary:** cough yellow/green sputum blood in sputum shortness of breath wheezing

**Gastrointestinal:** nausea vomiting diarrhea constipation pain blood in stool or vomitus heartburn difficulty swallowing

**Genitourinary:** incontinence abnormal bleeding abnormal discharge urinary frequency urinary hesitancy pain impotence sexual problem infection urinary retention

**Musculoskeletal:** pain stiffness joint redness/warmth arthritis back pain weakness muscle wasting sprain/fracture

**Neuro:** headache weakness dizziness change in voice change in taste change in vision change in hearing loss/change sensation trouble walking balance problem coordination problem shaking speech problem

**Patient Signature:**_____ **Date:**_____