



**MARTIN FOOT
AND ANKLE**

ADULT REGISTRATION FORM

717-757-3537 or 1-800-456-0076

www.martinfootandankle.com

Patient Information

Last Name		First Name		M.I.	Phone Number ()		<input type="checkbox"/> Home <input type="checkbox"/> Cell
Street Address			City	State	Zip	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Pharmacy		Email Address			Marital Status: <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Annulled <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married		
Patient's Employer		Occupation		Work Phone No. ()			
Race (check <u>one</u> which best applies): <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Decline/Unknown <input type="checkbox"/> Native Hawaiian/other Pacific Islander				Ethnicity: <input type="checkbox"/> Spanish/Hispanic Origin <input type="checkbox"/> Not of Spanish/Hispanic Origin <input type="checkbox"/> Declined/Unknown			
Preferred Language (select <u>one</u>): <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____ <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Decline/Unknown							
How did you hear about our offices? <input type="checkbox"/> Internet/Social Media <input type="checkbox"/> Billboard <input type="checkbox"/> Friend/ Relative <input type="checkbox"/> Radio <input type="checkbox"/> Television				<input type="checkbox"/> Referring Physician Name _____ <input type="checkbox"/> Other _____			

Spouse Information (if applicable)

Spouse's Name		Date of Birth
Spouse's Phone # ()	Spouse's Employer	

In Case of Emergency

Name	Phone Number ()
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Family Physician

Name of Family Physician/General Practitioner	Address	Phone Number ()
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I hereby give my permission for all physicians of Martin Foot and Ankle to administer treatment and to perform such procedures as may be necessary for the diagnosis and/or treatment of my foot and/or ankle condition.

Signature of Patient / POA / Responsible Party

Date

AUTHORIZATION STATEMENT:

I hereby authorize the processing of the medical insurance either by electronic or manual method of MARTIN FOOT AND ANKLE. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for payment of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Payment methods are: Cash, Check or Credit Card (Debit, Visa, MasterCard, Discover, American Express, and Care Credit)

Signature of Patient / POA / Responsible Party

Date

HEALTH HISTORY QUESTIONNAIRE

Doctor Signature _____

Patient's Full Name _____ Date _____

I prefer to be addressed as _____ Occupation _____

Medical Record Number _____ Date of Birth _____

Date Last Seen by PCP _____

Have you ever had any of the following conditions? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Arthritis | Type _____ | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis: Type A ____ B ____ C ____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Keloid/Thick Scar | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes: Type I ____ Type II ____ | Dialysis: Yes ____ No ____ | <input type="checkbox"/> Thyroid Problem |
| Insulin: Yes ____ No ____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venous Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> None of These |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nerve Disorder | |

Are you slow to heal after cuts? Yes No Have you had any other serious illness? Yes _____

Abnormal bruising, bleeding or scarring? Yes No Have you been hospitalized or been under medical care over 24 hours? Yes No
Explain _____

Do you have vascular grafts/stents? Yes No Have you had any surgery (if yes explain below with dates)? Yes _____

Do you have joint implants? Yes No _____

Do you have replacement heart valves? Yes No _____

Do you have a pacemaker? Yes No _____

Do you have a defibrillator? Yes No

Are you under active chemotherapy? Yes No

Do you have Sleep Apnea? Yes No

Do you use CPAP or BiPAP machine? Yes No

Did you ever smoke? Yes No Packs/Day ____ Years ____

Current smoker? Yes No Packs/Day ____ Years ____ Quit ____ When? ____ Vape? ____ E-cigarette? ____

Alcoholic Beverages? Yes No If yes, how often ____

Recreational Drugs? Yes No If yes, how often ____

Please List any Allergies (latex, penicillin, sulfa drugs, shrimp, Iodine), with reaction & severity

NONE

Please List any Medication/Dose or Supplements you are taking including any over the counter medication

See attached listing

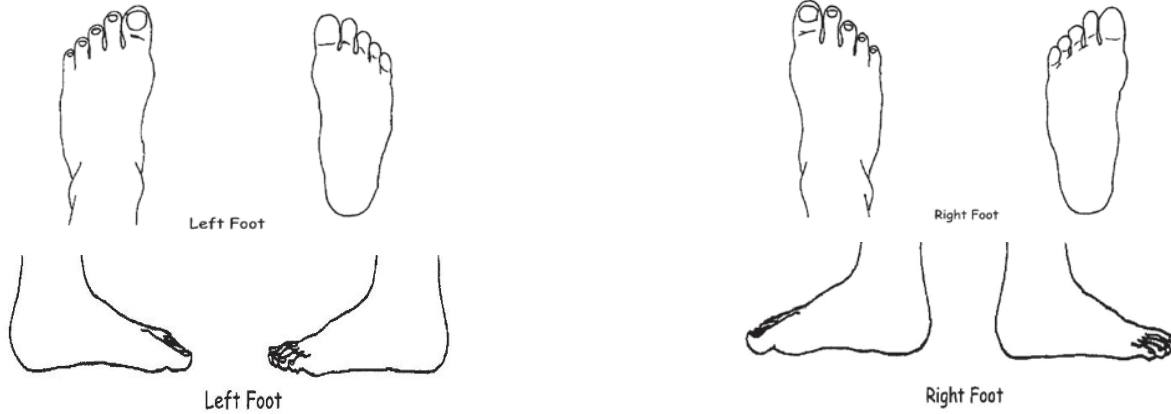
Family Health History: Please check any that apply to your Mother, Father, Brother and/or Sister

Diabetes M F B S Cancer M F B S

Arthritis M F B S Heart Attack M F B S

Stroke M F B S High Blood Pressure M F B S

Patient Signature _____



- Check here for Nail Care only Fungal Nails

On diagram above, please mark the location of your **First** foot problem with a # 1

- Shooting Pain Throbbing Pain Sharp Pain
 Burning Pain Itching Aching Pain
 Tenderness Dull Pain Tingling / Numbness

How long ago did the problem (pain) start? _____ days _____ weeks _____ months _____ years

Does the pain occur while walking? Yes No

Severity Light Moderate Strong

Is the problem work related? Yes No Date of Injury _____ Date reported to Employer _____

List previous medical treatments for this issue by physician or home remedies

On diagram above, please mark the location of your **Second** foot problem with a # 2

- Shooting Pain Throbbing Pain Sharp Pain
 Burning Pain Itching Aching Pain
 Tenderness Dull Pain Tingling / Numbness

How long ago did the problem (pain) start? _____ days _____ weeks _____ months _____ years

Does the pain occur while walking? Yes No

Severity Light Moderate Strong

Is the problem work related? Yes No Date of Injury _____ Date reported to Employer _____

List previous medical treatments for this issue by physician or home remedies

Have you ever been treated for or experienced any conditions of the foot and/or ankle?
(leg/foot ulcer, cramps in legs/feet, fungal nails, sprains, other)? Explain _____

Shoe Size _____

Did you previously, or do you wear: Who provided them? Podiatrist Orthopedist Store

Shoe Inserts Yes No Still using them Yes No Did they help Yes No

Orthotics Yes No Still using them Yes No Did they help Yes No

Are your first steps out of bed painful? Yes No Does pain subside? Yes No

Do you get leg cramps during the day? Yes No at night? Yes No

Patient Signature _____ Date _____