Dallas PODIATRY Works
Affiliate of WEIL FOOT & ANKLE USA

(Please Print)
REGISTRATION FORM

Today's Date ____/____/____ Facility _____ Doctor _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Work Phone #	E-mail Address
( ) -	( ) -	

Birth Date	Age	Social Security Number	Marital Status	Sex
/ /			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured Employer

Insured Employer Address

Please indicate primary insurance	Address of primary insurance carrier			Phone number ( ) -
Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment $

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _____.

Please indicate secondary insurance	Address of secondary insurance carrier			Phone number ( ) -
Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment $

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _____.

Referred to Institute by (Please use one) **Address**

☐ Doctor _____ _____

☐ Hospital _____ _____

☐ Insurance Plan _____ _____

☐ Family/Friend _____ _____

☐ Tribune ☐ Herald ☐ Sun Times ☐ T.V. ☐ Radio

☐ Other _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
To Dallas Podiatry Works

X _____ / /
Signature Date

HIPPA AUTHORIZATION
Necessary to process claims

X _____ / /
Signature Date

MEDICAL HISTORY

PATIENT NAME	BIRTH DATE / /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	HOW LONG?	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( ) -		
Street Address	City	State	Zip Code
Have you ever been put to sleep for surgery? ☐ **Yes** ☐ **No**			

SHOE SIZE	HEIGHT	WEIGHT
DO YOU DRINK?	☐ NO ☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO ☐ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems / Reflux / Heartburn	☐ Yes	☐ No
Hepatitis A (Infectious) B (serum)	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date

HISTORY REVIEWED BY: DR. SIGNATURE DATE

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Patient's Last Name	First	Middle	Birth Date
			/ /

DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I Decline to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ I Decline to Report

Preferred Language ☐ English ☐ Spanish ☐ Other _____

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Osco ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other _____

Address or Cross-Streets: _____

City: _____

State: __

Zip Code: _____

Phone Number: _____

Fax Number: _____

☐ This is a mailorder pharmacy

☐ I do not have a preferred pharmacy

I authorize Weil Podiatry of New York and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY
To Dallas Podiatry Works, LLC

X _____ / /
Signature Date