

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility \_\_\_\_\_ Doctor \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Sr.
				<input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> Jr.
Street Address		City	State	Zip Code
Home Phone # ( ) -	Work Phone # ( ) -	E-mail Address		
<b>Birth Date</b>	<b>Age</b>	<b>Social Security Number</b>	<b>Marital Status</b>	<b>Sex</b>
/ /			<input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Widow <input type="checkbox"/> Div	<input type="checkbox"/> M <input type="checkbox"/> F

**INSURANCE INFORMATION**

Occupation	Insured Employer				
Insured Employer Address					
<b>Please indicate primary insurance</b>	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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <b>Insured Birth Date</b> / /					
Insurance Type <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Public Aid <input type="checkbox"/> WC <input type="checkbox"/> OTHER _____					
<b>Please indicate secondary insurance</b>	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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <b>Insured Birth Date</b> / /					
Insurance Type <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Public Aid <input type="checkbox"/> WC <input type="checkbox"/> OTHER _____					

<b>Referred to Institute by (Please use one)</b>	<b>Address</b>
<input type="checkbox"/> Doctor	_____
<input type="checkbox"/> Hospital	_____
<input type="checkbox"/> Insurance Plan	_____
<input type="checkbox"/> Family/Friend	_____
<input type="checkbox"/> Tribune <input type="checkbox"/> Herald <input type="checkbox"/> Sun Times <input type="checkbox"/> T.V. <input type="checkbox"/> Radio	_____
<input type="checkbox"/> Other _____	

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

To Dallas Podiatry Works **X** \_\_\_\_\_ / /  
 Signature Date

**HIPPA AUTHORIZATION**

Necessary to process claims **X** \_\_\_\_\_ / /  
 Signature Date

## MEDICAL HISTORY

<b>PATIENT NAME</b>		<b>BIRTH DATE</b>		/	/	
<b>ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)</b>						
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Anti-inflammatory Medication			
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tape	<input type="checkbox"/> Nausea From Anesthetic	<input type="checkbox"/> Iodine on Skin			
<b>MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)</b>						
MEDICATION	DOSE	MEDICATION	DOSE			
<b>FOOT/ANKLE PAIN WHERE?</b>				<b>HOW LONG?</b>	<b>MONTHS</b>	<b>YEARS</b>
<b>WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?</b>						
<input type="checkbox"/> Surgery	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Oral Medications	<input type="checkbox"/> Cortisone Shots			
<b>FAMILY PHYSICIAN INFORMATION</b>						
Medical Doctors Name			Phone Number			
			(   ) -   -   -			
Street Address		City	State	Zip Code		
Have you ever been put to sleep for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>SHOE SIZE</b>		<b>HEIGHT</b>		<b>WEIGHT</b>		
<b>DO YOU DRINK?</b>		<input type="checkbox"/> NO	<input type="checkbox"/> YES	DRINKS PER WEEK		
<b>DO YOU SMOKE?</b>		<input type="checkbox"/> NO	<input type="checkbox"/> YES	PACK(S)/DAY		
<b>Indicate which of the following you have had or have at present. Check Yes or No to each item</b>						
Arthritis/Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Motion Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Problems / Reflux / Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hepatitis A (Infectious) B (serum)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers (Diabetic)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.						
<b>X</b>				/ /		
Patient/Guardian Signature				Date		
HISTORY REVIEWED BY: DR. SIGNATURE				DATE		



(Please Print)  
**REGISTRATION FORM**

Affiliate of  
**WEIL FOOT & ANKLE**  
USA

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility \_\_\_\_\_ Doctor \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name	First	Middle	Birth Date / /
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**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