

Date: \_\_\_\_\_

**Family Foot Clinic, PC**  
**702 Plank Road/South Hill, VA 23970**  
**804-447-3395 (p) 804-447-4979 (f)**

**PATIENT REGISTRATION FORM**

**GENERAL**

Patient's Name \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address \_\_\_\_\_ Soc Sec # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Tele # \_\_\_\_\_  
Home Work

Name of Spouse/Parent \_\_\_\_\_ Employer \_\_\_\_\_

**INSURANCE**

**Primary Insurance** \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_

**FINANCIAL**

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signed \_\_\_\_\_  
Patient or Parent if Minor Date

I authorize payment of medical benefits to myself or the names provided for professional services rendered.

Signed \_\_\_\_\_  
Patient or Parent if Minor Date

I authorize the release of any medical information necessary to process this claim

Signed \_\_\_\_\_  
Patient or Parent if Minor Date

***Thank you for choosing Family Foot Clinic***

## PATIENT INFORMATION SHEET

### Do you have or have you had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Foot or leg injuries | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> Foot or leg surgery  | <input type="checkbox"/> Heart trouble     | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Foot or leg cramps   | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Bleeder               |
| <input type="checkbox"/> Foot or leg numbness | <input type="checkbox"/> Liver disease     | <input type="checkbox"/> Stomach ulcers        |
| <input type="checkbox"/> Knee pain            | <input type="checkbox"/> Kidney disease    | <input type="checkbox"/> Blood disease         |
| <input type="checkbox"/> Unequal leg length   | <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Bursitis              |
| <input type="checkbox"/> Weak ankles          | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Polio                 |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Bunions           | <input type="checkbox"/> Prone to infection    |
| <input type="checkbox"/> Foot skin problems   | <input type="checkbox"/> Toe nail problems | <input type="checkbox"/> Gout                  |
| <input type="checkbox"/> Fainting spells      | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Varicose veins    | <input type="checkbox"/> Hardening of arteries |

### Are you allergic or sensitive to:

- Novacaine
- Penicillin
- Adhesive tape
- Materials
- Drugs
- Foods
- Other (if so, describe) \_\_\_\_\_

List Medications

List Surgeries