

Date: _____

Family Foot Clinic, PC
702 Plank Road/South Hill, VA 23970
434-447-3395 (p) 434-447-4979 (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