Name:_______________________________________ Date of Birth:_______________ Today's Date:____________

○ Mr. ○ Mrs. ○ Dr. ○ Ms. ○ Miss

Marital Status: Single / Mar / Div / Sep / Widow

Sex: ○ Male ○ Female

SSN:__________________

Billing Address: ____________________Apt:________ City/State: _________________ Zip Code:_______________

Phone Number: (Please specify what number we can leave a message)

Race: □ White □ Hispanic □ Asian □ American Indian □ African American □ Other

○ Home: _________________________ ○ Cell: _________________________

(If different from above)

Insurance Cardholder Name:______________________ DOB: ____________________ SSN:__________________

Employer:____________________________________

Emergency Contact & Relationship:__________________________________ Phone Number:______________________

If Patient is Under 18

Guarantor Name:______________________________ Relationship:_______________ Date of Birth:____________

Billing Address: _____________________Apt:_______ City/State/ Zip:______________ SSN:__________________

How did you hear about us?

We love referrals and like to show our appreciation of trust in the work and patient care we do and give. Please provide us with anyone who referred you to our care. Thank you.

Did someone refer you? ○ Yes ○ No

Physician:__________________________________

Urgent Care Facility:________________________

Friend/Patient:_____________________________

Primary Care Physician:

____

Location/ Facility Name:

____

Last date seen:

____

Is there any other doctor or facility you would like your records sent to?

____

____

Did you see/ hear one of our advertisements?

○ Newspaper ○ Event:___________ ○ Phone Book:__________ ○ Radio ○ Brochure ○ Insurance

○ Visit our website ○ Google Search ○ Other:_________________________

Patient Portal

Our patient portal is an online program that you can log into from any computer and get prescriptions filled, communicate with our MA's, and request your patient documents. An email address is required for this premier service and is also imperative to keep you up to date on new events and treatments in our office.

Email Address:____

We will never give your personal info to any outside source.

List any people who may receive information regarding your care:

____

____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Animas Foot and Ankle for foot and ankle care, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Animas Foot and Ankle may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits payable for related services.

Patient Signature: ____ Date: ___________________________

Animas Foot and Ankle

Patient Registration

REASON FOR VISIT

Vhich foot/ankle is bothering you: ☐ Right ☐ Left ☐ Both

Vhat is your specific foot or ankle problem:

____

____

Please check any symptoms:

☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing

☐ Cramping ☐ Itching ☐ Popping ☐ Burning

☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing

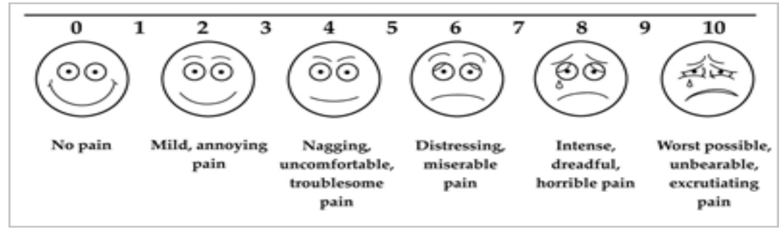
☐ Other: ______________________________

Vhat type of injury: ☐ Auto Accident ☐ Job Related ☐ Other

awyer Involvement: ☐ Yes ☐ No

Is this problem painful? ☐ Yes ☐ No

If yes, please rate your pain.



The problem is worse: ☐ AM ☐ PM ☐ At Rest ☐ With Activit

How long have you been experiencing this issue:

______ days ______ months ______ years

COMPREHENSIVE HEALTH REVIEW

Medications (include OTC and RX meds, and vitamins)

Med/Dose Med/Dose

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

What Pharmacy do you prefer:_________________________

Allergies

☐ None ☐ Latex

☐ Adhesives/ Tape ☐ Local Anesthetics

☐ Aspirin ☐ Penicillin

☐ Codeine ☐ Seafood/ Shellfish

☐ Cortisone ☐ Sulfa Drugs

☐ Iodine ☐ ________________

Past Medical History

☐ Diabetes I ☐ Diabetes II ☐ High Cholesterol

☐ Acid Reflux ☐ Immune Disorder

☐ Anemia ☐ Kidney Disease/ Dialysi

☐ Arthritis(Osteo/Rheum) ☐ Liver Disease

☐ Asthma ☐ Fibromyalgia

☐ Back Problems/Sciatica ☐ Lung Condition

☐ Blood Clot/ DVT ☐ Neuropathy

☐ Cancer:______________ ☐ Osteomyelitis

☐ Cellulitis/ Skin Infection ☐ Heart Attack/ Disease

☐ Circulation Problems ☐ Raynaud's Disease

☐ Dementia/Alzheimers ☐ Seizures/ Epilepsy

☐ Excessive/Easy Bleeding ☐ Stomach Ulcers

☐ Pregnant/Breastfeeding ☐ Stroke

☐ High/Low Blood Pressure ☐ Varicose Veins

☐ Other Problems:___________________________________

lame:____

Animas Foot and Ankle

Patient Registration

Family History (please specify family member (maternal or paternal) and if living (L) or deceased(D))

- □ Cancer
- □ Diabetes ______________________ L D
- □ Gout ______________________ L D
- □ Heart Disease ______________________ L D
- □ High Blood Pressure ______________________ L D
- □ Hypertension ______________________ L D
- □ Stroke ______________________ L D
- □ Mental Illness ______________________ L D
- □ Other ______________________ L D

ge______ Weight______ Height______ Shoe Size______

Past Surgeries

- □ Foot/ Ankle Surgery:________________________
- □ Joint Replacement:_________________________
- □ Open Heart/ Bypass □ Hernia Repair
- □ Hysterectomy □ Tubal Ligation
- □ C-Section
- □ Stent Placement: □ Leg □ Heart
- □ Cosmetic Surgery: __________________________
- □ Appendix □ Gallbladder
- □ Leg Bypass □ Open Fracture:____________
- □ Back Surgery □ Vein Surgery
- □ Carotid □ Thyroid
- □ Other: ___________________________________

SOCIAL HISTORY

Occupation:____

About how much do you stand in a day _______%

Who do you live with □ Spouse □ Children □ Parents □ No one

Do you play sports □ Yes □ No

List:____

□ My foot/ankle problem limits my activities

□ Alcohol usage

How much/Often?______________________

□ Tobacco usage Packs/Day?__________

If you quit, when?______________________

□ Marijuana usage

□ Exercise How many times a week?______

REVIEW OF SYMPTOMS

Constitutional
- □ Chills
- □ Fatigue
- □ Fever
- □ Headache

Peripheral Vascular
- □ Cold Extremities
- □ Pain/ Cramping in Legs after exertion
- □ Painful extremities

Gastrointestinal
- □ Abdominal Pain
- □ Diarrhea
- □ Vomiting
- □ Constipation
- □ Nausea

Musculoskeletal
- □ Muscle aches
- □ Arthritis
- □ Joint stiffness
- □ Leg Cramps
- □ Pain with range of motion
- □ Gout
- □ Pain with weight bearing

Neurologic
- □ Impaired Coordination
- □ Dizziness
- □ Headaches
- □ Tingling and Numbness

Cardiovascular
- □ Chest Pain
- □ Claudication Problems
- □ Dizziness
- □ Palpitations

Skin
- □ Hair Changes
- □ Masses
- □ Nodules
- □ Skin Lesions

understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that ne information I have provided will help me receive the care I need. I thank you for taking such an interest in my health.

(Patient Signature: Date: