

Patient Registration Form: *This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be release without your permission. (please print clearly)*

Name: _____ D.O.B.: ___ / ___ / ___ Age: _____ Sex: ___M ___F ___other
Weight: _____ Shoe Size: _____ Shoe type: _____

Social Security #: _____ Marital Status: ___Married___Single___Minor___Widow

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Who can we thank for referring you to us? **(Please specify)** _____
(Can we text you here? 🖱 Y / N)

Employer: _____ Work Phone: _____ Occupation: _____

Primary Doctor: _____ PCP Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

Patient's Parent/ Guardian Information: *(if under 18)*

Name: _____ Phone Number: _____

Pharmacy/ Prescription Information:

___ Rite Aid ___ CVS ___ Walmart ___ Target Other: _____

Address or Cross Streets: _____

Phone Number: _____ Fax Number: _____

Payment Information:

Primary Insurance -

Insurance: _____ ID #: _____ Group #: _____ Eff. Date: _____

Patient's Relationship to Insured: ___Self ___Spouse ___ Child other: _____

Insurance Type: ___PPO___EPO HMO ___POS ___Self Pay___Medicare

Secondary Insurance -

Insurance: _____ ID #: _____ Group #: _____ Eff. Date: _____

Patient's Relationship to Insured: ___Self ___Spouse ___ Child other: _____

Insurance Type: ___PPO___EPO___HMO___POS___Self Pay___Medicare

Chief Complaint/History of Present Illness:

What is the reason for your visit? _____

Which foot bothers you? Right Left How long has it bothered you? _____

When does it bother you the most? _____ When/what helps alleviate the pain? _____

Have you ever been to a Podiatrist before: Yes No If yes, please list: Name: _____ Last Visit: _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past:

<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Cramps/Numbness in feet or legs	<input type="checkbox"/> Ingrown Toenails
<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Flat feet	<input type="checkbox"/> Plantar warts
<input type="checkbox"/> Bunions	<input type="checkbox"/> Foot or leg cramps	<input type="checkbox"/> Swelling in ankles or Feet
<input type="checkbox"/> Corns & Calluses	<input type="checkbox"/> Discolored Toenails	<input type="checkbox"/> Tired feet
<input type="checkbox"/> Abnormal Gait: in/out toe	<input type="checkbox"/> Heel pain	<input type="checkbox"/> Fracture of Foot/Ankle

Ever had custom orthotics? Y N

Medical History:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Gastritis | <input type="checkbox"/> problems |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcer stomach | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Pulmonary problems | <input type="checkbox"/> problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Inflammation of veins | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Nervous condition | <input type="checkbox"/> HIV/AIDS |
| | | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Pace Maker |
- Other medical problems: _____

Please list all hospitalizations and surgeries with dates:

Include prescriptions, over the counter medications and vitamins:

****Are you ALLERGIC to any food/medicine?(please list)** _____

Social History:

Do you smoke? Yes No | Do you consume alcohol? Yes No | Do you use drugs? Yes No
 Females: Is there a possibility you could be pregnant? Yes No

Family History:

<input type="checkbox"/> Inherited disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Other
<input type="checkbox"/> Foot problems	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol	

I have read the above questions and I have answered them to the best of my knowledge. I authorize Dr. Emil Lavian, staff, and associates to examine and treat me. I also authorize the release of any medical information necessary to process medical insurance claims. In case my health insurance policy does not pay or cover my care expenses, I understand that I am responsible for payment.

Signature of Patient/Legal Guardian: X _____

Date: _____