EASTERN CT FOOT SPECIALISTS

PATIENT REGISTRATION FORM

This information is confidential

PATIENT INFORMATION

Name _____

Address _____

_____

City _____

State_____ Zip _____

Telephone (_____) _____

Cell Phone (_____)_____

Email: _____

Date of Birth _____

☐ Male ☐ Female

MARITAL STATUS

☐ Single ☐ Married ☐ Widowed ☐ Divorced

ETHNICITY

☐ American Indian or Alaskan Native ☐ Asian

☐ White ☐ Black or African American

☐ Native Hawaiian ☐ Hispanic Latino ☐ Other

EMPLOYMENT

Occupation _____

Employer _____

Work Phone_____ Ext._____

PRIMARY PHYSICIAN

Primary Physician_____

Date Last Seen By Primary Physician _____

PHARMACY INFORMATION

Pharmacy Name_____

City_____ State_____

PERSONAL REPRESENTATIVE / EMERGENCY CONTACT

(The individual authorized to discuss your personal health information if required)

Name _____

Relationship _____

Telephone (_____) _____

INSURANCE

Name of Policy Holder _____
(If not self)

Date of Birth of Holder _____

REASON FOR YOUR VISIT

_____

_____

_____

_____

_____

OVER PLEASE

HISTORY & MEDICAL INFORMATION

Name _____ Height _____

Date of Birth _____ Weight _____

PAST MEDICAL HISTORY - *Check all that apply:*

- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Other _____
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Lung/Respiratory Disorders
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Nerve Disorders
- ☐ Osteoarthritis
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Kidney Disease

ALL MEDICATION AND DOSAGE:

Medication	Dose	Frequency

ALLERGIES: _____

ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No

PAST FOOT SURGERY? ☐ Yes ☐ No

TOBACCO USE: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

IF OVER 65 YEARS OLD, DID YOU HAVE THE PNEUMONIA VACCINE? ☐ Yes ☐ No

FAMILY HISTORY - *Please check if there is family history of any of the following conditions and indicate (M) Mother or (F) Father:*

Diabetes	☐ M	☐ F	Rheumatology	☐ M	☐ F	Stroke	☐ M	☐ F
Kidney Disease	☐ M	☐ F	Cancer	☐ M	☐ F	Hypertension	☐ M	☐ F
Heart Disease	☐ M	☐ F	Bleeding Disorders	☐ M	☐ F	Mental Illness	☐ M	☐ F

Other family history: _____

_____