THE FOOT & ANKLE CARE CENTER, PA
DR. CHRISTOPHER PALADINO
239-498-1176 FAX 239-498-5877

PATIENT REGISTRATION

SOCIAL SECURITY______________________ **DATE:** ____________________

NAME ____

ADDRESS____

CITY______________________________ **STATE**__________________ **ZIP**________

PHONE ___________________________ **CELL** _______________________________

❏ check if we have permission to send automated messages to this number for appointment & account reminders

WORK____________________________ **EMAIL**_______________________________

DATE OF BIRTH_________________ **AGE**_______ **SEX**______ **STUDENT** YES__NO__

RACE: ___**WHITE** ___ **BLACK or AFRICAN AMERICAN** ___ **HISPANIC**
___ **ASIAN** ___ **AMERICAN or NATIVE INDIAN** ___ **OTHER**_________________

PREFERRED LANGUAGE: _______________________

PREFERRED METHOD OF CONTACT BY OUR OFFICE: ___**HOME PHONE** ___**MOBILE**

PLEASE CIRCLE MARITAL STATUS: **S M D W DOMESTIC PARTNER**

EMERGENCY CONTACT____

RELATIONSHIP__________________________ **PHONE NUMBER**________________

HOW WERE YOU REFERRED TO OUR OFFICE?

INTERNET___ WEBSITE___ INSURANCE CO___ DOCTOR REFERRAL___
FRIEND___WALK-IN ___ PHONE BOOK ___ OTHER_____________________________

OCCUPATION____

EMPLOYER NAME & ADDRESS____

MEDICAL INFORMATION & HISTORY

*****HEIGHT**________ *****WEIGHT**_______ **SHOE SIZE & WIDTH**_______________________
ARE YOU DIABETIC? YES_______ NO_______
IF YES: TYPE I_______ OR TYPE II_______ CONTROLLED______ UNCONTROLLED______

REASON FOR TODAY'S VISIT (PLEASE CIRCLE ALL THAT APPLY)

___FOOT PAIN LEFT/RIGHT/BOTH
___ANKLE PAIN LEFT/RIGHT/BOTH
___ATHLETE'S FOOT LEFT/RIGHT/BOTH
___BUNIONS LEFT/RIGHT/BOTH
___CORNS & CALLUSES LEFT/RIGHT/BOTH
___CRAMPS OR NUMBNESS IN FEET OR LEGS LEFT/RIGHT/BOTH
___FLAT FEET LEFT/RIGHT/BOTH
___FUNGUS LEFT/RIGHT/BOTH
___HEEL PAIN LEFT/RIGHT/BOTH
___INGROWN TOENAILS LEFT/RIGHT/BOTH
___PLANTAR WARTS LEFT/RIGHT/BOTH
___SWELLING IN ANKLES OR FEET LEFT/RIGHT/BOTH
___NAIL TRIMMING
___OTHER____

LIST ALL DRUG ALLERGIES & REACTIONS

NO KNOWN DRUG ALLERGY_____
____
____

LIST ALL CURRENT MEDICATIONS & DOSAGE

____
____
____
____

PATIENT NAME: ____
PRIMARY CARE PHYSICIAN_________________________ **PHONE** _________________
PHARMACY PHONE_________________________
PHARMACY NAME & ADDRESS____
If address is unknown, please state the intersection of it's location**

PLEASE CHECK ALL THAT APPLY:

____NONE	___SWELLING-ANKLE-FOOT	
___AIDS/HIV	___FAINTING	___ULCERS
___ANEMIA	___GOUT	___VARICOSE VEINS
___ANGINA	___HEADACHES	___WEIGHT LOSS
___ARTHRITIS	___HEARING LOSS	___DIZZINESS
___ASTHMA	___HEART CONDITION	___ EPILEPSY
___BACK PROBLEMS	___HIGH CHOLESTEROL	___THYROID DISORDER
___BLOOD PRESSURE	___KIDNEY PROBLEMS	___TREMORS
___CANCER	___NEUROPATHY	___STROKE
___CIRCULATION	___NUMBNESS/TINGLING	___OTHER
___CRAMPS	___DIABETES	

DO YOU SMOKE? CURRENT SMOKER____ FORMER SMOKER____NEVER SMOKER____

DO YOU DRINK ALCOHOL? NEVER____ OCCASIONAL_____MODERATE____ HEAVY____

FAMILY HISTORY

______ UNKNOWN ______ NON-CONTRIBUTORY

Relation:	Problem:
______________________________	____
______________________________	____
______________________________	____

PAST SURGICAL HISTORY

____

____

____

RECORD RELEASE FORM

PATIENT NAME: ____

DATE OF BIRTH: ____

SOCIAL SECURITY NUMBER: _XXX-XX-____

LIST ALL DOCTORS WITH MEDICAL RECORDS NEEDED FOR APPOINTMENT BELOW

REQUESTING RECORDS FROM:

DOCOR(S)/HOSPITAL(S): ____

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE NUMBER: ____

FAX NUMBER: ____

LIST PEOPLE ALLOWED ACCESS TO ALL YOUR HEALTH INFORMATION BELOW

____

____

____

X____

SIGN DATE

☐ PLEASE CHECK THIS BOX **IF** WE HAVE PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR **HOME PHONE VOICEMAIL BOX**

☐ PLEASE CHECK THIS BOX **IF** WE HAVE PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR **MOBILE VOICEMAIL BOX**

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is medically privileged, confidential and exempt from disclosures under the applicable law. If you have received this communication in error, please notify us immediately by telephone and return this original message to us at the address below.

Thank you,

The Foot and Ankle Care Center
28089 Vanderbilt Dr., Ste. 104
Bonita Springs, FL. 34134
Phone: (239) 498-1176
Fax: (239) 498-5877

NAME__________________________________ DATE________________________

DATE OF BIRTH____/____/______

LIFETIME AUTHORIZATION

I authorize financial information and reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with your referring doctor, the doctor requesting consultation, your family physician, as well as any other health care providers, hospitals, or outpatient facilities that I have or will identify to you. I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agents of my insurance companies or to my employer if this is a worker's compensation claim, any information needed for this or a related insurance or Medicare claim. I permit a copy/fax of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

Patient Signature____

MEDIGAP AUTHORIZATION (SECONDARY INSURANCE)

I request that payment of authorized Medigap benefits be made on my behalf for any services furnished me by that physician. I authorize any holder of medical information about me release to primary/secondary/tertiary/Medigap carriers any information needed to determine these benefits or the benefits payable for related services. This authorization applies to all occasions of service until it is revoked in writing by me. Copies of my insurance cards are attached.

Patient Signature____

FINANCIAL AUTHORIZATION

I understand that I am fully and legally responsible for all charges for services rendered which includes all outstanding balances not covered by Medicare and/or insurance companies. I understand that failure to pay my account or to make suitable financial arrangements to pay my account will result in my account being turned over to a collection agency. Should it be necessary to take my debt to collection, I agree to pay all collection costs which include, but are not limited to fee, court costs, attorney fees and any other fees or cost for the collection of my account balance.

Patient Signature____