# Family Foot And Ankle Clinic, LLC

**2405 Schofield Ave #110**
**Weston Wi 54476**
**(715)241-8100**

**117 Main Street**
**Marathon, WI 54448**
**(715)443-3300**

**Patient Registration Form**

**PATIENT INFORMATION DATE: _____**
**NAME: _____**
**ADDRESS: _____**
**_____**
**PHONE: home _____ work _____cell _____**

**E-MAIL ADDRESS: _____**
**Employer: _____**
**Social Security#_____**
**Age: _____ Date of Birth: _____**
**Occupation:_____**
**Sex: o Male o Female**
**Marital Status: o Single o Married o Separated o Divorced o Widowed**
**Spouse's name (parent's name, if child) _____Day Phone:**
**_____**

**Emergency Contact: Name:**
**_____**
**Relationship: _____Phone: _____**
**Referring Doctor: _____**
**Address and/or Phone: _____**

**INSURANCE INFORMATION**

**Primary Insurance:**
**_____**
**ID# Group Plan**
**Name of insured: _____**
**Insured's SSN: _____**

**Secondary Insurance: _____**
**ID# Group Plan _____**
**Name of insured: _____**
**Insured's SSN: _____**

**Does your insurance require pre-authorization, certification, or second opinion?**
**O Yes O No**

**If yes, please provide the phone number for contact:**
**_____**

**RELEASE OF INFORMATION/ PAYMENT AUTHORIZATION**

**I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to Family Foot And Ankle Clinic, LLC for services rendered. I realize I am responsible for payment of charges not covered by insurance.**
**I certify that the information I have reported with regard to my insurance coverage is correct.**

**Signature _____**

**Date _____**

**PATIENT HISTORY FORM**
**Please fill out the following confidential form for our records.**

**Patient Name: _____**

**Age: ___ Height: ___ Weight: ___ Shoe Size _____**

**Current Foot or Ankle problem:**
**_____**

**When did the problem start?**
**_____**
**What has been done to treat the problem?**
**_____**
**Are you now or have you ever been under a physician's care in the past two years?**
**_____**
**If yes, please explain:**
**_____**

**Name of Family Physician: _____**
**Date last seen: _____**
**Name of Former Podiatrist: _____**
**Date last seen: _____**
**What conditions were you treated for:**

**MEDICAL HISTORY**

**_ Diabetes _ Kidney or Bladder _ Cancer**
**_ Gout _ Bleeding Disorders (sickle cell) .. Epilepsy / Seizures**
**_ Heart Disease _ Anemia/Blood _ Depression or Anxiety**
**_ High Blood Pressure _ Asthma/Bronchitis _ Vascular/Circulatory**
**_ Stroke or Heart Attack _ Rheumatic Fever Disease**
**_ Stomach Ulcer / Reflux _ Accident/Injuries _ Arthritis**
**_ Thyroid Disease _ Immune Disease _ Foot Problems**
**_ Liver Disease (HIV, AIDS) _ Other**
**Please explain any positive responses above (i.e. hepatitis for liver disease):**
**_____**
**_____**
**__**

**MEDICATIONS, (please include dosage of each)**

**1) _____ 5)_____**
**2) _____ 6)_____**
**3) _____ 7)_____**
**4) _____ 8)_____**

**ALLERGIES, (penicillin, novocaine, tape, foods, etc.)**

**1)_____ 3)_____**
**2)_____ 4)_____**

**SURGERIES and HOSPITALIZATIONS (describe procedure, year and any complications)**

**1) _____**
**2)_____**
**3)_____**
**4) _____**

**SOCIAL HISTORY**

**Occupation: _____**
**Tobacco: If yes, how much? _____**
**Alcohol: If yes, how much? _____**
**Illicit drugs: If yes, how much? _____**
**FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other):**
**_____**
**_____**
**_____**
**___**

**Whom may we thank for referring you to our office?**
**_____**
**I hereby give Family Foot and Ankle Clinic, LLC permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.**

**Signature:_____**
**Date: _____**

**There will be times this office will call and leave messages regarding appointments**