JOHNSTON FOOT & ANKLE CLINIC PATIENT REGISTRATION SHEET

Patient Information

First _____ Last _____ M _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home# _____ Cell # _____ Email: _____

Please Circle: Male or Female Social Security # _____ Language _____

Please Circle Marital Status: Single/Married/Divorced/Widowed/Partner **Ethnicity:** Hispanic/Latino or Non-Hispanic

Please Circle Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Islander White

Primary Care Physician _____ **Date Last Seen** _____

Employer Name, Address, Phone #:

_____

_____

Responsible Party (Guarantor)

First _____ Last _____ M _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Email: _____

Social Security # _____ Relationship to patient _____

How did you hear about our office? _____

Emergency Contact _____ **Phone #** _____

Do we have permission to talk to this person regarding your health? Yes / No

I/We do hereby consent to and authorize the performance of any/all treatments, surgeries and/or medical services deemed advisable by Dr. Dana L. Plew, DPM at Johnston Foot & Ankle Clinic, to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that to the best of my knowledge, all statements contained heron are true. I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Johnston Foot & Ankle Clinic to release any/all information requested by insurance companies and/or its representatives, collection agencies and/or any attorney's office and/or any physician, surgery center or hospital. The signature below will also count as my "signature on file" for any/all insurance purposes. I fully understand this agreement and consent will continue until cancelled by me in writing.

Print Name of Patient/Responsible Party

_____ ***Date*** _____

Signature of Patient/Responsible Party

_____ ***Date*** _____

Pharmacy Name/Address_____

Please list any/all medications and dosages: *I do not take any medications* □

_____

_____

_____

_____

_____

_____

_____

Please list any/all allergies to medications: *No Known Allergies* □

_____

_____

_____

Past Medical History: *Please circle any/all that apply*

*None Allergies/Medicine Anxiety/Depression Arthritis Asthma A-Fib Cancer CAD COPD Crohn's Diabetes Gallbladder GERD Heart Hepatitis C High Blood Pressure/Low Blood Pressure High Cholesterol Liver Migraines Thyroid Other*_____

Past Surgical History: *Please circle any/all that apply*

None Adenoidectomy Angioplasty Appendectomy Arthroscopy Knee right/left/both Back Breast C-Section Carpal Tunnel Release right/left/both Cataract Colon Foot right/left/both Gastric Bypass Hernia Hip right/left/both Hysterectomy Kidney Knee right/left/both LASIK Liver Pacemaker Prostrate Thyroidectomy Tonsillectomy Tubal Ligation Vasectomy Other: _____

Family History: *Please circle any/all that apply*

Cancer- mother/father Diabetes- mother/father Heart Disease- mother/father Stroke- mother/father

Social History: *Please circle any/all that apply*

*Smoker Yes/No How much do you smoke?*_____

*Caffeine Yes/No How much do you drink?*_____

Have you had any of the following vaccines? ***Flu/Pneumonia/Shingles***

What is your: Height _____ *Weight*_____