CONFIDENTIAL PATIENT REGISTRATION ***Please use black ink***

- Patient's Name: _____ Age: _____Birth Date: _____

  Street Address: _____ City: _____ State: _____Zip: _____

  Mailing Address (if different)_____

- Email Address_____

  Home Phone: _____ Cell Phone: _____ Patient's Social Security #:_____

- Marital Status (circle one): S M D W Name of spouse: _____

- Emergency contact & relationship: _____Phone: _____

- Employer (or your father's if you are a minor): _____Phone:_____

- Spouse's employer (or your mother's if you are a minor)_____Phone: _____

- How did you hear about us? (**circle one**) Internet Friend/Family Physician Referral Insurance Other _____

- **Please explain patient's present problem in <u>full detail</u>:** (Include foot, ankle, knee, thigh, and hip complaints) _____

_____

_____

- Who is your Medical Dr.? _____Date Last Seen_____

  Address:_____ Phone #:_____

- Who is responsible for patient's account? (Circle one): SELF SPOUSE FATHER MOTHER GUARDIAN

- **NAME OF INSURANCE**: 1ST_____2ND_____

(Please show insurance cards to the receptionist)

<u>PLEASE GIVE NAME & ADDRESS OF INSURED PERSON</u> <u>(If different than your own)</u>

Name:_____Birth Date:_____SS#:_____

Address:_____City _____ State:_____Zip:_____

- <u>PLEASE CIRCLE (YES) OR (NO) TO THE ALL OF THE FOLLOWING QUESTIONS:</u>

1.	DO YOU HAVE ANY OCCUPATIONAL CONCERNS?	YES	NO
2.	ARE YOU IN GOOD HEALTH?	YES	NO
3.	HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST TWO YEARS?	YES	NO
4.	ARE YOU PREGNANT OR PLAN TO BE IN THE NEAR FUTURE? DUE DATE_____	YES	NO
5.	DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL WORK & SURGERIES?	YES	NO
6.	DO YOU HAVE A TENDENCY TO GET INFECTIONS FROM MINOR INJURIES?	YES	NO
7.	HAVE YOU EVER SMOKED OR USED TOBACCO?	YES	NO

IN THE PAST - PACKS / DAY_____ CURRENTLY - PACKS / DAY _____

- WHAT MEDICATIONS ARE YOU PRESENTLY TAKING? PLEASE PRESENT LIST TO BE PHOTOCOPIED:

_____PHARMACY NAME: _____

- MINORS ONLY: Name of Parent(s) or Legal Guardian(s):_____

(Please present copy of custody agreement if pertinent)

Address:_____City:_____State:_____Zip:_____

- **I certify that the above information is true and correct to the best of my knowledge**.

PATIENT/GUARDIAN SIGNATURE: _____**DATE**:_____