REGISTRATION DATA

PLEASE PRINT

Patient Name_____

Date of Birth_____ Age_____ Sex ❒ M ❒ F

Home Address_____

City _____

State_____ Zip Code_____

Employer_____ Work Phone_____

Spouse's Name_____

Ethnicity/Race _____

Today's Date_____

Marital Status ❒ Married ❒ Single

Email _____

Phone #_____

Cell #_____

Referred By: ❒ Internet ❒ Phone Book

❒ Physician _____
(Physician's Name)

❒ Other (specify)_____

Family Physician_____

Former Foot Doctor_____

Language _____

WHAT ARE YOUR FOOT AND ANKLE CONCERNS?_____

_____

ANY PAIN / CONCERNS WITH HIP, KNEE'S OR BACK? _____

	YES	NO
1. Are you in good health?	❒	❒
2. Is there any personal or family history of diabetes? Who is your diabetes doctor?_____	❒	❒
3. Have you ever experienced any allergies to **any** medications? Latex? Tape? If yes, which one(s)?_____	❒	❒
4. Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver involvement? If yes, which one(s)?_____	❒	❒
5. Have you had any serious illnesses or operations? If yes, please explain _____ _____	❒	❒
6. Eye Exam? When?_____ Doctor?_____	❒	❒
7. Have you ever had stomach ulcers or problems taking medications such as Aspirin or Motrin?	❒	❒
8. Use of Alcohol? If yes, average per day / week _____	❒	❒
9. Use of Tobacco? If yes, average per day / week_____	❒	❒

I hereby give my permission to **DR. JOHN D. ARSEN** and/or **DR. KRISTI S. SCHONS** to administer treatment and to perform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or hand condition.

I also request that payment of authorized benefits be made to the provider on my behalf for any services furnished me by this provider. I authorize **DR. JOHN D. ARSEN** and/or **DR. KRISTI S. SCHONS** to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related service. I understand that I am ultimnately responsible for the balance on my account for any professional services rendered.

DATE_____ **SIGNATURE** _____

LEGAL GUARDIAN (if patient is under 18)_____