MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

Patient Registration Form

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ SS#: _____ Sex: M or F Marital Status: Single/Married/Widowed

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a confidential message on your answering machine? Yes or No

Email Address: _____

Race: _____ Hispanic or Non-Hispanic Primary Language: _____

Employer: _____ Occupation: _____

Emergency/Alternate Contact: Please list any additional people you authorize us to speak with regarding your health/appointments.

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

How did you hear about our office?

- ☐ Patient Referral: _____
- ☐ Doctor Referral: _____
- ☐ Facebook
- ☐ Google
- ☐ Radio
- ☐ Digital Ad
- ☐ Other: _____

Insurance Information:

Primary Insurance:

_____

Secondary Insurance:

_____

Subscriber of Insurance:

_____

DOB of Subscriber:

_____

Phone Number of Subscriber:

_____

Relationship to Subscriber:

_____

Do you have HSA or FSA?

_____

Guarantor Information:

(Person who holds financial responsibility for patient statements)

Guarantor Name:

_____

Guarantor address:

_____

Guarantor Phone Number:

_____

Guarantor DOB:

_____

Work Related Injury:

Is your visit today associated with a work related injury? Yes or No

Date of Injury:

_____

Claim Number:

_____

Claim Adjuster Name:

_____

Phone:

_____

Email:

_____

Workers Comp Carrier:

_____

Milwaukee Foot and Ankle Specialists will bill your insurance company on your behalf for your services. I authorize my insurance benefits to be paid directly to Milwaukee Foot and Ankle Specialists. I understand that I am financially responsible for my balance. I also authorize Milwaukee Foot and Ankle Specialists and/or insurance company to release any information required to process my claims. This agreement will remain in effect until revoked by myself in writing. A copy of this document is considered valid as the original. The above information is true to the best of my knowledge. I will notify Milwaukee Foot and Ankle Specialists of any changes.

Patient or Guardian Signature: _____ Date: _____

MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

Patient Registration Form

Patient Medical History:

PrimaryCarePhysician:_____ Phone:_____ DateLastSeen:_____

Pharmacy: _____ Location/Cross Streets: _____

What are you being seen for today? _____ When did your condition begin? _____

Please rate your pain on a scale of 0-10 (10 being the worst pain you can imagine) 0 1 2 3 4 5 6 7 8 9 10

Is this a work related injury? Yes OR No If yes, please give the date of injury: _____

Height: _____ Weight: _____ Shoe Size: _____

Hobbies: _____

Do you smoke? Yes OR No How many packs per day? _____ How many years? _____

Do you drink alcohol? Yes OR No How frequently? Rarely Socially Daily

Do you exercise? Yes OR No Type of activity: _____ Frequency: _____

Are you diabetic? Yes OR No If yes, do you take insulin? Yes OR No

Have you ever been treated for any of the following conditions? (Check all that apply)

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Liver problems
- ☐ Pacemaker
- ☐ Blood clots
- ☐ HIV
- ☐ Heart trouble
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Hepatitis C
- ☐ Stroke
- ☐ Asthma

Family Medical History:

- ☐ Diabetes
- ☐ Cancer
- ☐ Blood clots
- ☐ Stroke
- ☐ Asthma

Significant Past Medical History (please list):

_____

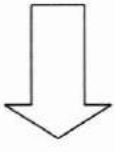
Please list ALL medications you are currently taking or attach medication list:

_____

Please list ANY allergies to ANY medications: _____

Please list ANY major surgeries (within the last 10 years): _____

PLEASE SEE REVERSE SIDE OF THIS PAGE



MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

Patient Registration Form

Review of Symptoms:

General:
- ☐ Unexpected weight loss/gain
- ☐ Fevers
- ☐ Chills
- ☐ Fatigue

Eyes:
- ☐ Corrective lenses
- ☐ Blurred/double vision
- ☐ Eye pain
- ☐ Redness
- ☐ Watering

ENT:
- ☐ Headaches
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Earaches

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Murmurs
- ☐ Poor circulation
- ☐ Cold feet
- ☐ Calf pain

Respiratory:
- ☐ Shortness of breath
- ☐ Sneezing
- ☐ Coughing
- ☐ Chest tightness
- ☐ Chest pain
- ☐ Snoring

Gastrointestinal:
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Bleeding
- ☐ Colitis
- ☐ Crohn's
- ☐ Ulcers

Genitourinary:
- ☐ Renal failure
- ☐ Difficult urination
- ☐ Flank pain
- ☐ Kidney stones

Musculoskeletal:
- ☐ RA
- ☐ Lupus
- ☐ Gout
- ☐ Joint pain
- ☐ Swelling
- ☐ Instability
- ☐ Stiffness
- ☐ Redness
- ☐ Deep muscle pain

Skin:
- ☐ Unusual changes
- ☐ Poor health
- ☐ Rash
- ☐ Itching
- ☐ Redness
- ☐ Ulcerations
- ☐ Infections

Neurologic:
- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizure
- ☐ Stroke
- ☐ Weakness
- ☐ Drop foot

Psychiatric:
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Hematologic:
- ☐ Easy bleeding
- ☐ Bruising
- ☐ Cancer
- ☐ Coumadin
- ☐ Blood thinners

Endocrine:
- ☐ Excessive thirst or urination
- ☐ Heat/cold intolerable
- ☐ Thyroid (high or low)

Doctor Signature: _____ Date: _____