

**GLOBAL FOOT & ANKLE CLINIC
OAK BROOK MEDICAL ASSOCIATES, S.C.**

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Tel: 630-990-9500 Fax: 630-990-9501

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Patient Name: _____
First Initial Last

Address: _____

City: _____ State: _____ Zip Code : _____

Social Security # _____ Home Phone # (_____) _____

Work Phone # (_____) _____ Cell Phone # (_____) _____

E-Mail address _____ **Sex:** Male Female

Employer _____

Address: _____

Patient's Date of Birth: ____/____/____ Referred By: _____

Marital Status: Single Married Divorced Separated Widowed

MEDICAL INSURANCE INFORMATION

Subscriber Name: _____ SS#: _____

Relationship to Patient: _____ Carrier Name: _____

Policy #: _____ OR Group Name / Group # _____

Secondary Insurance Information:

Subscriber Name: _____ SS#: _____

Relationship to Patient: _____ Carrier Name: _____

Policy #: _____ OR Group Name / Group # _____

EMERGENCY CONTACT: Name _____

Relationship: _____ Phone _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____
(Subscriber) Date _____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signed _____
(Subscriber) Date _____

PATIENT'S HISTORY

NAME : _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE _____ WIDTH _____

CHIEF COMPLAINT: _____

How long has this bothered you? _____ Which Foot? LEFT RIGHT BOTH

GENERAL HEALTH? GOOD FAIR POOR

Do you have diabetes? YES NO Last Blood Sugar _____ Diabetes in the family? YES NO

Do you have PAIN, CRAMPS, SWELLING, TINGLING, or NUMBNESS in your feet or legs? YES NO

Please explain: _____

Do you bruise easily? YES NO Do you have lower back pain? YES NO

Are you taking any medications? YES NO

If yes, please list: _____

Do you smoke? YES NO Do you drink? YES NO

Have you had any past surgeries or hospitalizations? YES NO

If yes, please list: _____

For WOMEN: Are you, to your knowledge, pregnant? YES NO

ALLERGIES - Are you allergic or sensitive to: Penicillin Novocain Anesthetics Adhesive tape

I am not allergic to anything that I know of. Drugs _____

Other _____

FAMILY HEALTH: Have you or a family member of yours, ever had the following?

- | | |
|---|--|
| • Heart trouble <input type="checkbox"/> You <input type="checkbox"/> Family | • Epilepsy <input type="checkbox"/> You <input type="checkbox"/> Family |
| • Kidney trouble <input type="checkbox"/> You <input type="checkbox"/> Family | • Varicose Veins <input type="checkbox"/> You <input type="checkbox"/> Family |
| • High Blood Pressure <input type="checkbox"/> You <input type="checkbox"/> Family | • Arthritis <input type="checkbox"/> You <input type="checkbox"/> Family |
| • Liver Problems <input type="checkbox"/> You <input type="checkbox"/> Family | • Cancer <input type="checkbox"/> You <input type="checkbox"/> Family |
| • Circulatory Problems <input type="checkbox"/> You <input type="checkbox"/> Family | • Rheumatic Fever <input type="checkbox"/> You <input type="checkbox"/> Family |
| • Bleeding Problems <input type="checkbox"/> You <input type="checkbox"/> Family | • Asthma <input type="checkbox"/> You <input type="checkbox"/> Family |

Any other medical conditions? _____

I certify the above information is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

Podiatrist comments: _____

Signature: _____ D.P.M. Date: _____