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

488 S. River Rd., Des Plaines, IL 60016
2425 W. 22nd St., Suite 215, Oak Brook, IL 60523
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	**RELEASE OF INFORMATION**
I authorize payment of medical benefits to myself or the named provider for professional services rendered.	I authorize the release of any medical information necessary to process this claim.
Signed _____ (Subscriber)	Signed _____ (Subscriber)
Date _____	Date _____

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

488 S. River Rd., Des Plaines, IL 60016
2425 W. 22nd St., Suite 215, Oak Brook, IL 60523
Tel: 630-990-9500 Fax: 630-990-9501

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	☐ You	☐ Family	• Epilepsy	☐ You	☐ Family
• Kidney trouble	☐ You	☐ Family	• Varicose Veins	☐ You	☐ Family
• High Blood Pressure	☐ You	☐ Family	• Arthritis	☐ You	☐ Family
• Liver Problems	☐ You	☐ Family	• Cancer	☐ You	☐ Family
• Circulatory Problems	☐ You	☐ Family	• Rheumatic Fever	☐ You	☐ Family
• Bleeding Problems	☐ You	☐ Family	• Asthma	☐ You	☐ 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: _____