**FOOT AND ANKLE CENTER OF TEANECK REGISTRATION** **PLEASE PRINT**

Last Name:_____ First Name:_____ MI:_____

Address: _____ City: _____ State:_____ Zip:_____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Emergency Contact:_____ Phone: (___) _____ Relationship: _____

E-Mail: _____

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Family Physician: _____ Phone Number: (___) _____

Fax Number: (___) _____

Birth Date: ____/____/_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer:_____ Employer Address:_____

__FULL TIME___PART TIME __NOT EMPLOYED __SELF EMPOYED___RETIRED __ACTIVE MILITARY DUTY __STUDENT

Pharmacy: _____ Pharmacy Phone Number: (___) _____

**Referred by:** _____

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**HOW DID YOU HEAR ABOUT US:** **Phone Book** ☐ **Insurance** ☐ **Internet** ☐ **Friend/Family** ☐

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**RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES**

*I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.*

Name Phone Number Relationship

_____

_____

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**ASSIGNMENT OF INSURANCE BENEFITS**

*The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.*

*I, _____ , herby authorize_____ to pay and herby assign directly to Foot and Ankle Center of Teaneck all benefits. I further acknowledge that any insurance benefits, when received by and paid to Foot and Ankle Center of Teaneck will be credited to my account, in accordance with the above said assignment,*

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**Agreed & Authorized**: _____ **Date**: _____

**SOCIAL HISTORY**

Do or Did you smoke cigarettes? ☐Yes ☐No If Yes, packs per day?_____ Stop date: _____

Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No

Allergies to any medication? ☐Yes ☐No If Yes, which medications? _____

Place of Birth? _____ Unusual Occupational Exposures? _____

Please list ALL medications you are currently taking: _____

_____

_____

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## MEDICAL HISTORY:

Previous Surgery/Hospitalizations _____

_____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

**FAMILY HISTORY** (check if anyone in your family has had or had the following)

| | MOTHER | FATHER | SILBINGS | CHILDREN | OTHER RELATIVE |
|---|---|---|---|---|---|
| CANCER | | | | | |
| DIABETES | | | | | |
| HEART DISEASE | | | | | |
| ARTHRITIS | | | | | |
| OSTEOPOROSIS | | | | | |
| AGE (IF LIVING) | | | | | |

**SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Chronic Headaches/Migraines** | | | **Diabetes** | | |
| **Dizziness** | | | **High Blood Pressure** | | |
| **Fainting Spells/Blackouts** | | | **High Cholesterol** | | |
| **Eye Disease/Glaucoma/Cataracts** | | | **Joint Pains/Swelling** | | |
| **Double Vision** | | | **Swelling of ____Feet _____Ankles** | | |
| **Recent Vision Impairment** | | | **Numbness/Tingling of hand/Feet** | | |
| **Impaired Hearing** | | | **Color Changes in the Hands** | | |
| **Ringing in the Ears** | | | **Chest Pressure/Chest Pain** | | |
| **Dryness of _____Eyes _____Mouth** | | | **Chronic Back Pain** | | |
| **Recent Hair Loss** | | | **Chronic Neck Pain** | | |
| **Asthma** | | | **Parkinsonism** | | |
| **Recurrent Fever** | | | **Osteoporosis** | | |
| **Thyroid Disorder** | | | **Sciatica** | | |
| **Pneumonia** | | | **Anemia or Blood Disorder** | | |
| **Pleurisy** | | | **Skin Rash** | | |
| **Frequent Cough** | | | **Psoriasis** | | |
| **Tuberculosis Exposure** | | | **Recent Weight ____Gain _____ Loss** | | |
| **Difficulty Breathing** | | | **Loss of Appetite** | | |
| **Coughing Up Blood** | | | **Constant Thirst or Hunger** | | |
| **Rheumatic Fever** | | | **Stomach/Duodenal Ulcer** | | |
| **Difficulty Urinating** | | | **Abdominal Pain/Heart Burn** | | |
| **Painful/frequent Urination** | | | **Frequent Nausea/Vomiting** | | |
| **Blood in Urine** | | | **Heart Murmur** | | |
| **Nighttime Urination _____Times** | | | **Cancer** | | |
| **Prostate Disorder** | | | **Palpitations** | | |
| **Recurring Bladder Infections** | | | **Convulsions OR Epilepsy** | | |
| **Kidney Disease/Stones** | | | **Hepatitis/Jaundice** | | |
| **Pancreatitis** | | | **HIV Virus Positive** | | |
| **Diverticulitis** | | | **Chronic Anxiety** | | |
| **Phlebitis** | | | **Depression** | | |
| **Insomnia** | | | | | |

Date of: Most Recent Medical Exam _____

EKG _____ Blood Tests _____ Chest X-Ray _____

**Women ONLY:** Date of last Mammogram: _____