BLUFFTON Foot & Ankle

Patient Registration Form

PATIENT INFORMATION

Name _____ Date _____

Street Address _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone # ( ) _____ Cell Phone # ( ) _____

Sex: ☐ Male ☐ Female Age _____ Birthdate _____

Employer _____ Email _____

Occupation _____ Marital Status: Single Married Separated Divorced Widowed

Emergency Contact _____ Relationship: _____ Phone #: _____

POLICY HOLDER INFORMATION

PRIMARY

Primary Insurance Company _____ Policy Holder's Name _____

Street Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____

Effective Date _____ Sex: ☐ Male ☐ Female Relationship to Patient _____

Employer _____ Business Phone # ( ) _____

Policy Holder's Birthdate _____ Social Security # _____

SECONDARY

Secondary Insurance Company _____ Policy Holder's Name _____

Policy # _____ Group # _____

Effective Date _____ Sex: ☐ Male ☐ Female Relationship to Patient _____

Policy Holder's Birthdate _____ Social Security # _____

RESPONSIBLE PARTY INFO.

Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # ( ) _____ Cell Phone # ( ) _____

GENERAL INFO.

How did you find out about our office Internet _____ Doctor _____ Friend _____ Sign _____

If by Doctor or Friend please name so we can thank them _____

Family Doctor's Name _____ Phone # ( ) _____

Family Doctor's Address _____

I authorize Dr. Daniel Kirk to furnish my insurance company with all the necessary information regarding my present illness or injury. I also authorize payments of medical benefits to Bluffton Foot & Ankle for medical supplies or services provided, with the understanding that any overpayment will be reimbursed to me promptly. I also understand that I am responsible for services or supplies not covered under my insurance contract. A photocopy of this authorization shall be considered as effective and valid as the original. This assignment will remain in effect until revoked by me in writing. I also authorize Dr. Daniel Kirk to examine and treat my condition.

Signature: _____ Date: _____

PRESENT COMPLAINT:_____

_____

ALLERGIES:

Medication Allergies: _____

_____

Food Allergies: _____

_____

Other Allergies: _____

Height: _____

Weight: _____

Shoe Size: _____

Pharmacy Used: _____

PAST SURGICAL HISTORY:

_____

_____

_____

_____

FAMILY HISTORY:

_____ **Lung Disease**

_____ **Heart Disease**

_____ **Cancer**

_____ **Diabetes**

_____ **High Blood Pressure**

_____ **Other:** _____

MEDICAL HISTORY:

____ **Asthma**
____ **Bleeding Disorders**
____ **Cancer**
____ **COPD**
____ **Diabetes**
____ **Gout**
____ **Heart Disease**
____ **Hepatitis**
____ **High Blood Pressure**
____ **High Cholesterol**
____ **HIV**
____ **Kidney Disease**
____ **Osteoarthritis (DJD)**
____ **Pacemaker**
____ **Pregnant Currently**
____ **Rheumatoid Arthritis**
____ **Stomach Ulcers**
____ **Thyroid**
____ **Other:** _____

_____

CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY: (Please Circle)

Alcohol History: Never Previously Occasional Daily

Tobacco History: Never Previously Chews

Currently Smoking: _____ **Packs per day**

Substance Abuse: Never Previously Occasional

AUTHORIZATION FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made to Bluffton Foot & Ankle on my behalf to the Physician for any services furnished to me by Dr. Daniel Kirk. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits of the benefits payable for related services. This agreement will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original.

Signature:_____ **Date:** _____