

## Patient Registration Information

Patient Name: \_\_\_\_\_

Home/Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: M  D  W  S

Primary Care Dr: \_\_\_\_\_ Last seen: \_\_\_\_\_

Referred by: Yellow Pages  Doctors Office  Insurance Co.  Patient  Other

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

*\*\*Please complete for responsible party if other than the patient or if patient is a child\*\**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell #: \_\_\_\_\_

### Insurance Information

Primary: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

*I understand as patient/guarantor that I am responsible for all services rendered. I give my permission for my insurance to be filed for the services rendered and not paid for at the time of service. I understand that if my insurance company denies the claims or if referrals are not properly obtained that I am responsible for all charges incurred. I authorize payment of medical benefits directly to Mendoza Foot & Ankle Center from my insurance company. I give Dr. Mendoza permission for my treatment, as he may deem medically necessary.*

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

First Name:

MI:

Last Name:

Shoe Size:

Weight:

Height:

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies) No Yes If yes, what happens?

- Penicillin
Other antibiotics (list below)
Empirin, Tylenol (if yes circle)
Aspirin, Advil, Aleve, or Motrin (circle)
Celebrex, Bextra, Vioxx (circle)
Other pain remedies (list below)
Morphine
Codeine
Demerol
Other narcotics (list below)
Novocaine
Other anesthetics (list below)
Sulfa drugs
Adhesive tape
Shrimp, Iodine, or Merthiolate
Any other drugs or medications.

Others:

List relationship to you of family members who have had:

- Diabetes
Arthritis
Stroke
Cancer
Foot Problems
Heart Attack
High Blood Pressure
Birth Defects

Are you currently taking any medications? List below! Yes No

Are you taking Insulin? If yes, list below. Yes No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

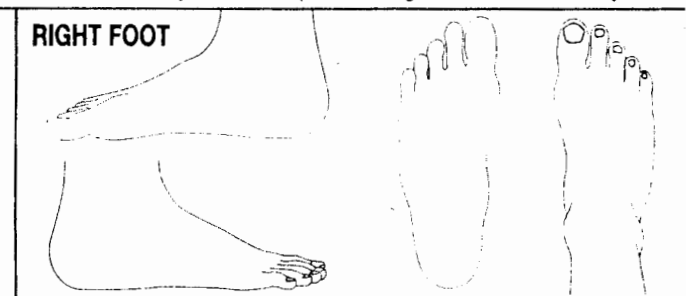
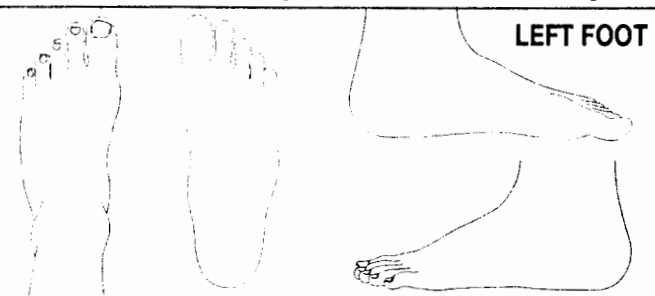
List: Medications Dose? How Often? For Treatment of?

Table with columns for Medication, Dose, Frequency, and Treatment. Includes rows for A, x, D, W.

Did you previously or do you now wear:

- Shoe inserts? Still using them? Do or did they help?
Orthotics? Still using them? Do or did they help?

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain to the right

My first problem is ... On Left foot On Right foot On Both feet. It causes me difficulty: walking, wearing shoes, and/or it ...

- Shooting Pain
Throbbing Pain
Sharp Pain
Burning Pain
Itching
Aching Pain
Tenderness
Dull Pain
Tingling
Numbness

Is problem work related? Yes No
Date of injury: / / Date of report to employer: / /

- Have you had/been treated for: Warts, Athlete's Foot, Corns/Calluses, Fungal Nails, Ingrown nails, Leg or Foot Ulcers, Neuroma, Foot Numbness, Broken foot bone(s), Broken Ankle, Ankle sprain, Hammer/Mallet toes, Bunions, Flat feet, Cramps in legs/feet, Arch pain, High arch feet, Lower back pain, Knee pain, Heel pain, Gait (Walking) problems, In-toeing, Toe walking, Childhood foot problems, Rash, NONE of these

Do you have or have you ever been treated for:

- Stroke, Heart Attack, High Blood Pressure, Phlebitis, Vascular Disease, A Heart Condition, Anemia, Poor Circulation, Eyes: Glaucoma/Macular Deg., Diabetes, Kidney Disease, Keloid/Thick Scar, Gout, Osteoporosis, Alzheimer's, Sciatica, Lyme's Disease, Rheumatic Fever, Arthritis, Headaches, Hearing/Ear Disorder, Epilepsy, Nerve Disorder, Psychiatric Disorder, Asthma, Lung Disease, Tuberculosis, Hepatitis, Liver Disease, Thyroid Problem, Dark Urine, Chronic Lt. Stool, Unexplained Weight Loss, Cancer, Stomach Ulcer, NONE of these, Other(s):

I Had Surgery for: on date of: w/ complications of:

Do you smoke now? No Yes Packs/day Years

Did you ever smoke? No Yes Packs/day Years

If you quit, when did you do so?

Alcoholic beverages? (Circle one) None Rarely Moderately Daily Quit

Recreational Drugs? (Circle one) None Rarely Moderately Daily Quit

Does foot pain limit your desired activities? Yes No

Do you have any difficulty in walking? Yes No

Any pain in calves or buttocks when walking? Yes No

Is the pain relieved by stopping & standing still? Yes No

Are your first steps out of bed painful? Yes No ... then subsides? Yes No

Do you get leg cramps ...during the Day? Yes No ...at Night? Yes No

Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

PAIN: Please indicate the severity of your pain or discomfort: None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is: Shooting Pain, Throbbing Pain, Sharp Pain, Burning Pain, Itching, Aching Pain, Tenderness, Dull Pain, Tingling, Numbness. How long ago did the problem (pain) start?: days, weeks, months, years ago. The pain from my problem occurs: while walking and/or while not walking, and/or: Previous medical treatment(s) or home remedies: