PATIENT REGISTRATION

CHEROKEE FOOT AND ANKLE CENTER

PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Street Address _____City_____ State _____ Zip_____

Home Phone # _____Cell #_____ Work #_____ Email:_____

Patient/Guardian approves the following: Text notifications? ☐ Yes ☐ No Voice Notifications? ☐ Yes ☐ No
(Message & Data rates may apply)

What is your preferred method of communication? ☐ Email ☐ Mail ☐ Home phone ☐ Mobile phone ☐ Work phone

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Non-Specified Race:_____ Preferred Language: _____

Who referred you ? ☐ Dr._____ ☐ Yellow Pages ☐ Internet ☐ Insurance Co. ☐ Our Website ☐ Other:_____

Patient's Employer/Student: _____

Person to contact in case of emergency: _____ Phone # _____

Person (other than yourself) whom we may share your personal health information:

Name:_____ Relationship:_____ Phone#:_____

Primary Physician _____ City _____ Last Visit _____

Former Foot Doctor _____ City _____ Last Visit _____

PARTY RESPONSIBLE FOR BILL (If different from patient):

Relationship to Patient _____ Name _____

Address _____ State _____ Zip _____

Phone # _____ Birth Date _____

Employer _____ Phone # _____

Address _____ City _____State _____Zip _____

INSURANCE INFORMATION:

If you don't have insurance, how will you be paying: ☐ Cash ☐ Check ☐ Credit Card

Insurance #1 _____ Insurance #2 _____

ACKNOWLEDGEMENT:

- I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.
- I authorize the release of any medical information necessary to process claims. I further authorize payment of medical benefits directly to the physician for services rendered.
- Notice of Privacy Practices: I have read (or had the opportunity to read) and understand the HIPAA privacy and compliance practices maintained by Cherokee Foot & Ankle Center.

Signature of Patient/Responsible Party:_____

Printed Name of Patient/Responsible Party:_____ Date:_____

Cherokee Foot & Ankle Center
Scott M. Cohen, D.P.M.
Diplomate, American Board of Podiatric Surgery

Name:_____ **Date of Birth: _____**

Medical Information (Please check the following):

☐ Arthritis	☐ Anemia	☐ Asthma
☐ Autoimmune Disease	☐ Blood Clots in your Legs or Feet	☐ Blood Disease
☐ Cancer	☐ Charcot Joint Disease	☐ Diabetes (circle Type I or II)
☐ Epilepsy / Seizures	☐ Eye Disease/Glaucoma/Cataracts	☐ Foot Cramps
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis A, B, or C
☐ HIV Positive	☐ High Blood Pressure	☐ High Cholesterol
☐ Thyroid Conditions	☐ Kidney Disease	☐ Leg Cramps / Numbness
☐ Liver Disease	☐ Mental Health Condition	☐ Mitral Valve Prolapse
☐ Osteoporosis	☐ Poor Circulation	☐ Pregnant, if female
☐ Rheumatic Fever	☐ Sores/Ulcers on Feet	☐ Stomach Ulcers or Acid Reflux
☐ Stroke	☐ Varicose Veins or Phlebitis	

If you answered yes to any of the above, please explain_:_____

Surgical History (please circle any that apply):
Angioplasty, Appendectomy, Back Surgery, Breast Biopsy, Bypass Surgery-Heart, Bypass Surgery-Leg, C-Section, Carotid Artery, Cataract, D & C, Dental Surgery, Gallbladder, Hernia Repair, Hysterectomy, Joint Replacement-Hip, Joint Replacement-Knee, Kidney Stones, Mastectomy, Pacemaker, Prostate Surgery, Stents-Heart, Stents-Leg, Tonsillectomy, Vein Stripping,
Other_____

Previous Foot Surgery (please circle any that apply):
Ankle Surgery, Spurs (other than heel spurs), Toenail Surgery, Heel Spur Surgery, Neuroma Excision, Hammertoe Repair, Plantar Fascial Release, Excision of Infected Bone, Toe Amputation, Bunion Surgery, Ankle Fracture Repair, Foot Fracture Repair, Ankle Fusion, Foot Fusion, Other_____

Please list any medications that you are currently taking:_____

Family History (please circle if positive):

Has anyone in your family (parents, children, siblings) had any of the following:

Cancer_____ Diabetes_____ Heart Disease_____ High Blood Pressure_____ Stroke_____
Relation Relation Relation Relation Relation

Social History (please complete):

Tobacco Use: Yes No Packs/Day:_____ No. Years:_____

Alcohol Use None Rarely Occasional Socially Daily

Are you allergic to: ☐ **None**

☐ Aspirin	☐ Codeine	☐ Penicillin	☐ Cortisone	☐ Adhesives/Tape	☐ Sulfa
☐ Iodine	☐ Shellfish	☐ Anesthetics	☐ Latex	☐ Other_____	

If yes, what kind of reaction did you experience:_____

What kinds of foot problems you are currently experiencing: Right Foot Left Foot Both Feet

☐ Heel Pain	☐ Ingrown Toenail	☐ Plantar Wart(s)	☐ Bunion	☐ Hammertoe
☐ Neuroma (Pinched Nerve)		☐ Fracture(s)	☐ Ankle Pain	☐ Diabetes Related Problem

☐ Other (please describe):_____