Welcome to our office
Birch Tree Foot and Ankle Specialists Registration Form

Name:_______________________________________ Middle Initial: _____ Date of Birth:_________________

Street Address:______________________________ City:____________________ State:______ Zip:___________

Home Phone: _________________Cell Phone:_______________ Social Security Number:_________________

Insurance Policy Holder's Name: _________________________ Date of Birth Policy Holder:_________________

Which phone number would you like us to call first if we need to contact you? (Circle one) **Home** **Cell**

May we send you a text message regarding your upcoming appointment? **Yes** **No**

Race: _____________ Ethnicity(circle one): **Hispanic** **NonHispanic** Primary Language:_________________

Email Address: ____ Height ___________ Weight ________________

May we contact you via email with healthcare information or office updates occasionally? **Yes** **No**

Family Doctor:_____________________________ Date Last Seen by Family Doctor:______________________

Pharmacy Name, City, Street: ____

Emergency contact: Please list any additional persons you authorize us to speak with regarding your protected healthcare information/appointments:

Name: _______________________________ Phone:______________________ Relationship: _______________

Name: _______________________________ Phone:______________________ Relationship: _______________

How did you hear about our office? **Doctor Name: _______________** **Family/Friend** **Google** **Facebook**

Your Personal Medical History (Place an "X" next to any conditions you have been treated for):

	Skin Conditions		**Endocrine Disorders**		**Respiratory**		**I have/had Cancer**
	Eczema		Diabetes		COPD		Cancer Type:
	Psoriasis		Thyroid Low or High		Sleep Apnea		**Cardiology**
	Athlete's Foot		Other:		I use a CPAP		Heart attack
	Plantar Warts				I use Oxygen		Atrial Fibrillation
	Fungal Nails		**Blood Disorders**		Asthma		High Blood Pressure
	Foot Ulcer/Open sore		DVT (Blood clot in leg)		Emphysema		Low Blood Pressure
	Other:		Pulmonary Embolism				
			HIV/AIDS		**I have kidney disease**		**Musculoskeletal**
	Neurological		Hepatitis B		**I am on Dialysis**		Osteoarthritis
	Seizure		Hepatitis C		**I have a pacemaker/defibrillator**		Rheumatoid Arthritis
	Epilepsy		Clotting disorder		**I have bad blood flow in my legs**		Joint Replacement
	Stroke		Bleeding disorder		**Other:**		Gout

Your Personal Surgical History: List any Foot and Ankle surgeries you have had, the year you had it, and surgeon name if possible: (This is important if we need to track down any old records.)

1. ____ Year:______
2. ____ Year:______
3. ____ Year:______

Please list any other surgeries you have had in the past:

1. ____ Year:______
2. ____ Year:______
3. ____ Year:______
4. ____ Year:______

Have you ever had any problems with anesthesia? If so, what? ______________________________

Have you ever been hospitalized? If so, for what? ______________________________

____

Have you ever been addicted to pain medications/narcotics? Yes (Drug name:_______________) No

Are you in a pain management program? Yes, currently Yes, I have been in the past No, never

Allergies: Please list any allergies to medications and any reactions you have to the medication:

1.______________________ Type of reaction:______________________

2.______________________ Type of reaction:______________________

3.______________________ Type of reaction:______________________

Current Medications: Please list drug name, the dose you take, and what the medication is for if possible. If you brought your meds list, just write "See meds list" and give us a copy of the list for your chart)

Drug Name	Dose	Reason Taking Medication
1.		
2.		
3.		
4.		

Other Meds:____

Social History

Employer: ____________________ Occupation:___________________________ ☐ I am retired

Does your job require long periods of **standing** or **walking**? **Yes, constantly** **Yes, occasionally** **Yes, rarely** **No**

Patient Name:____

Do you normally use a CANE or WALKER when you walk? **Yes** **No**
Do you exercise regularly? **Yes** **No** _____ times/week Type of exercise:___________________________
Do you use, or have you ever used any tobacco products? **Yes** **No** If yes, how often? ________________ packs/day for ______ years.
Do you consume alcohol? **Yes, socially** **Yes, on rare occasion** **No, none at all**
If you do consume alcohol, have you ever been diagnosed with or treated for alcoholism? **Yes** **No**
Do you use recreational or medical marijuana in any form? **Yes** **No**
Do you need any information from us regarding these substances in order to help you quit? **Yes** **No**

Family Medical History: Please list any medical conditions your immediate relatives have been treated for:

Mother: Age:_____ Health: Good Poor Deceased (age_____): Medical Conditions:_______________________
Father: Age:_____ Health: Good Poor Deceased (age_____): Medical Conditions:_______________________
Siblings: Age:_____ Health: Good Poor Deceased (age_____): Medical Conditions:_____________________

Review of Body Systems (Circle all that apply)

Constitutional	**Dermatological**	**Allergy**	**ENT**	**Ophthalmology**	**Endocrine**	**Respiratory**
Weight loss/gain	Rash	Runny nose	Headache	Eye Redness	Fatigue	Chest pain
Fevers	Itching	Itchy eyes	Difficulty Swallowing	Change in vision	Excessive sweating	Cough
Chills	Infection	Ear fullness	Nose bleeds	Cataracts	Excessive Thirst	Asthma
Fatigue	Callous	Sinus congestion	Ringing in ears	Glaucoma	Excessive Urination	Sleep apnea
Night sweats	Deformed Nails		Ear ache	Diminished vision	**Diabetes**	Shortness of breath
Weakness	Wound/Ulcer		Sore throat		Thyroid issues	
Cardiology	**Gastrointestinal**	**Heme/Lymph**	**Musculoskeletal**	**Neurologic**	**Urology**	**Psychology**
Chest Pain	Heartburn	Swollen glands	Joint pain	Numbness/Tingling	Kidney stones	High stress level
Palpitations	Bleeding/Ulcers	Fatigue	Joint Swelling	Weakness	Difficult urination	Depression
Leg Swelling	Loss of appetite	Loss of appetite	Joint Stiffness	Unsteady gait	Dialysis/Renal Failure	Anxiety
Foot/Ankle Swelling	Vomiting	Night Sweats	Arthritis	Recent Fall	Urinary Tract Infection	Panic Attacks
	Diarrhea	Anemia	Back Pain	Dizziness		

Please help us understand the purpose of your visit today: (Write "N/A" if the question does not apply to you.)

What are we seeing you for today? ____

Have you seen another physician or therapist for the issue? Yes (Who?___________________________) No

When did your issue begin?(List a specific date if you can think of one)________________________________

What were you doing when you first noticed the issue? ____

Have you ever had previous episodes of this?____

What makes the issue better?____

What makes the issue worse? ____

Is the issue affecting your ability to work? Yes, constantly Yes, occasionally Yes, rarely No, not at all

Is the issue limiting you from your hobbies? Yes, constantly Yes, occasionally Yes, rarely No, not at all

Has the issue gotten worse since it began initially? ____

Where is the issue located? ____

Is there any radiating pain that travels up towards your leg or down towards your toes? Yes No

Rate any pain at its worst on a 0-10 scale? (0 = no pain 10 = severe) _________ Average Pain level: ________

Is there a time of day or certain things you do where the issue is more noticeable?______________________

What kinds of things have you tried for the issue to try and make it better? ______________________________

Do any of these words help describe the issue? Burning Itching Locking Swelling Tingling Numbness

Throbbing Sharp Shooting Dull Ache Pins/Needles Other:_____________________________

I understand Birch Tree Foot and Ankle Specialists (BTFAS) will bill my insurance company on my behalf for services provided. I authorize my insurance benefits to be paid directly to BTFAS. I understand that I am financially responsible for my balance. I also authorize BTFAS and/or insurance company to release any information required to process my claims. This agreement will remain in effect until revoked by myself in writing. A copy of this document is considered valid as the original. The above information is true to the best of my knowledge. I will notify BTFAS of any changes.

Patient or Guardian Signature: ____ Date: ____________________

By signing below, I acknowledge that I have received or reviewed a copy of this office's Notice of Privacy form.

Patient or Guardian Signature:____ Date: ____________________

Physician Signature: ____ Date:____________________