CHARLOTTE FOOT CLINIC
4300 PARK ROAD
CHARLOTTE NC 28209
704 716 3338

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Social Security Number: _____ - ____ - _____ Sex: Male [ ] Female [ ]

Marital Status: Married [ ] Single [ ] Divorced [ ] Widowed [ ]

Patient's Name: _____ Date of Birth: ____/____/____

Address: _____ Home Telephone: _____

Cell Phone: _____

City: _____ States: _____ Zip: _____

Name of Nearest Relatives: _____ Telephone: _____
Who is your Family Physician? _____ Telephone: _____
Are You Under treatment at this time? ___ Last Date You Saw Him ____/____/____

Have you ever seen a Podiatrist? ____ If Yes Date Last Seen ____/____/____

How did you hear about CHARLOTTE FOOT CLINIC _____

RESPONSIBLE PARTY EMPLOYMENT INFORMATION

Employer's Name: _____ Occupation: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

IN ORDER FOR US TO FILE YOUR INSURANCE WE MUST HAVE A COPY OF YOUR INSURANCE CARD (FRONT & BACK). PLEASE GIVE YOUR CARD TO THE RECEPTIONIST FOR COPYING. IF YOU HAVE MORE THAN ONE INSURANCE, YOU MUST PRESENT BOTH CARDS FOR COPYING.

Name of Insured: _____ Date of Birth: ____/____/____

Relationship of Insured to the Patient: Self [ ] Spouse [ ] Parent [ ]

I authorize Dr. Thomas P. Whitfield to release any information acquired in the course of my examination or treatment and permit payment of insurance benefits to be paid directly to him any benefits due me for services rendered. I further understand that I will be responsible for any unpaid balance remaining after payment of such benefits. I understand that it is my responsiblity to contact my insurance should they fail to pay or pay less than anticiapted.

_____ Date: ____/____/____
Signature of Patient/Responsible Party

PAST MEDICAL HISTORY

Circle the Appropriate Answers

Diabetes	No	Yes
Low Blood Pressure	No	Yes
High Blood Pressure	No	Yes
Arthritis	No	Yes

Have you ever been treated in an Emergency Room? _____ (If Yes give dates and what you were treated for): _____

If you have had any illness other than normal childhood diseases please list illness and approximate dates: _____

_____

If female, how many children do you have? ___ Normal Delivery ____ C Section

Do you smoke? _____ If Yes, how many packs a day?_____

Do you have any problems with your back? ____ If Yes, Explain: _____

_____

Do you have any problems with circulation? ____ if Yes, Explain _____

Do you eat a special diet? _____ If yes, explain: _____

List all medications you are taking, their dosage, and the number of times a day you take them:

_____

_____

Are you allergic to any Medications? ____ If Yes, List them: _____

Are you allergic to any food, pollen, mold, etc.? ___ If Yes, List them: ____

_____

Have you ever had any type of surgery? ____ If Yes List Date and Type of Surgery _____

_____

What type of problem are you having with your feet and/or ankles? _____

_____

How long have you had this problem? _____

Was this a result of an accident? _____ Date of accident: ____/____/____