P A T I E N T R E G I S T R A T I O N F O R M

PATIENT INFORMATION

Date: ________________ Patient Name: ____

Address: ____

Street City State Zip code

Birth date: ______________________ Patient Social Security #: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone:_____________________

Sex (circle): Male Female **Marital Status** (circle): Single Married Widowed Separated Divorced

Race /Ethnicity (circle): White Black/African American Asian Hispanic/Latino Other______________________

Patient Occupation:____ Employer:________________________________

Employer Address:____ Employer Phone #:_______________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_______________________________ Phone #:_______________________ Relationship to Patient:_________________

*****OPTIONAL:** I give your office permission to speak to ____on my behalf regarding my appointments and/or billing issues and/ or medical information.

INSURANCE INFORMATION

Please provide your insurance card to us to copy for billing purposes

Name of Insurance Co.:____

Member ID#:____ Group #:___________________________________

Complete the following if someone other than the patient is the subscriber to the Insurance Policy:

Name of Subscriber/Insured:____ Birth date:_________________________

Relation to Patient:____ S.S. # of Subscriber:___________________________

Do you have a secondary/additional health insurance policy? If Yes, please complete:

Name of Insurance Co.: ____

Member ID#:__________________________________ Group #:________________________

Fill out the following if someone other than the patient is the subscriber to the Insurance Policy:

Name of Subscriber/Insured:________________________ Birth date:_____________________

Relation to Patient:______________________ S.S. # of Subscriber:______________________

AUTHORIZATION OF TREATMENT & AUTHORIZATION OF PAYMENT/RELEASE OF MEDICALINFORMATION

I hereby authorize Dr. Todd Karas to render treatment he deems medically necessary in order to treat my foot/ankle condition. I authorize Associates of Sterling Podiatry to release all information necessary to secure payment of insurance benefits. I hereby authorize my insurance company to make payment directly to Associates of Sterling Podiatry for all professional and related services. I understand that I am fully liable for all charges including any amount my insurance company does not pay. In the event my bill is not paid in a timely manner, information that is helpful for collection purposes will be forwarded to a professional collection company. If outside collection attempts are necessary, I will be responsible for all collection and legal fees.

Signature of Patient/Guardian: X____ Date:_________________

Relationship of Guardian to Patient: ____

********* **PLEASE TURN OVER TO FILL OUT MEDICAL HISTORY**********

(Please check one) How were you referred to our office?

____ Your Doctor (doctor's name____________________________)
____ Another Patient (patient's name_________________________)
____ Internet Search
____ Your Insurance Plan
____ Yellow Pages

MEDICAL INFORMATION

What is the chief complaint for which you are seeking treatment?
____

Family physician: ____ Date of last visit: ___________________________

Do you have any personal or family history of diabetes? ____

Are you now, or have you been, under any other doctor's care for any reason within the past two years?
If yes please explain: ____
____
____
____
____

List any surgeries and/or hospitalizations ____
____
____
____

List any known allergies:
____

List any medications/vitamins you currently use____
____
____
____
____

What is your Preferred Pharmacy for prescriptions?
(Please give Name & location city/street)____

MEDICAL HISTORY

Please checkmark if you have had any of the following:

___AIDS/HIV
___Eye problems
___Phlebitis/Blood clot
___Allergies to Anesthetics
___Fainting
___Psychiatric care
___Allergies to medicine
___Gout
___Rash
___Artificial heart valves
___Heart disease
___Respiratory disease

___Bleeding disorders
___Hemophilia
___Rheumatic fever
___Cancer
___Hepatitis or Jaundice
___ Shortness of breath
___Chemical dependency
___High blood pressure
___Stroke
___Chest pain
___Kidney problems
___Swelling in ankles/feet

___Arthritis
___Circulatory problems
___Liver disease
___Tired feet
___Diabetes
___Low blood pressure
___Ulcers
___Epilepsy
___Nervous problems
___Varicose veins
___Sleep apnea
___Back pain