SETH M. ANDERSON, D.P.M., FACFAS

MISSOURI FOOT AND ANKLE

JOHN J. HOFFMAN, D.P.M., FACFAS

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____
Number Street City, State Zip

Phone: (___) _____ (___) _____ (___) _____
Home Work Cell

Social Security Number: _____ Date of Birth: _____ E-mail Address: _____

Sex: ☐M ☐F Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Name of Spouse: _____ Emergency Name & Phone # _____

Referred to Missouri Foot & Ankle by: ☐Magazine ☐Doctor _____ ☐T.V. ☐Internet
Name

☐Yellow Pages ☐Hospital ☐Family _____ ☐Insurance Book/Directory
Name

☐Friend _____ ☐Other _____
Name Name

INSURANCE INFORMATION

Insured's Name: _____ Occupation/Employer: _____

Address: _____
Number Street City, State Zip

Relationship to Patient _____ Insured's Social Security Number: _____

Date of Birth: _____ Phone: (___) _____ (___) _____
Home Work

Subscriber I.D.# _____ Group # _____

A Note About Insurance

Insurance policies are contracts between you the subscriber and the company. The doctor can in no way alter the contract nor guarantee your payments by the company. All fees are rendered to the patient or responsible party. If unpaid balances are turned over to collections, you will be responsible for any incurred debts thereafter. Copayments are due at time of visit.

HMO SUBSCRIBERS

You must have a referral from you Primary Care Physician. If you do not have a referral for your office visit, you are responsible for payment in full.

_____ _____ _____
Signature of Patient Date Signature of Parent/Guardian

ST. JOHN'S MEDICAL CENTER
621 S. NEW BALLAS RD
SUITE 7005B
ST. LOUIS, MO 63141
(314) 991-FOOT (3668)
FAX (314) 991-3665

ST. MARY'S HEALTH CENTER
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SUITE 411
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ARNOLD, MO 63010
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MEDICAL HISTORY

Patient Name:_____ D.O.B._____ Age_____

Height:_____ Weight:_____ Shoe Size_____

Family Doctor:_____ Date Last Seen:_____

Do you Smoke? ☐Yes ☐No _____Pack(s)/day/years Do you Drink? ☐Yes ☐No _____Drinks/week

Indicate which of the following you have had or have at present. Check Yes or No to each item.

Arthritis/Rheumatism ☐Yes ☐No
Artificial Joints (hip,knee,etc.) ☐Yes ☐No
Asthma/Lung Disorder ☐Yes ☐No
Bleeding Disorder/Tendency ☐Yes ☐No
Blood Clots ☐Yes ☐No
Cancer ☐Yes ☐No
Diabetes ☐Yes ☐No
Fibromyalgia ☐Yes ☐No
Glaucoma ☐Yes ☐No
Gout ☐Yes ☐No
Heart (Surgery, Disease, Attack) ☐Yes ☐No
Heart Murmur ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
H.I.V. Positive ☐Yes ☐No
Joint/Back Pain/Stiffness ☐Yes ☐No
Kidney Trouble ☐Yes ☐No
Liver Disease/Hepatitis ☐Yes ☐No
Neurological Disorder ☐Yes ☐No
Numbness In Feet/Legs ☐Yes ☐No
Peripheral Vascular Disease ☐Yes ☐No
Psychiatric/Psychological Care ☐Yes ☐No
Scarring Tendency ☐Yes ☐No
Stomach Problems/Reflux/Heartburn/Ulcers ☐Yes ☐No
Stroke ☐Yes ☐No
Swelling In Feet ☐Yes ☐No

ALLERGIES: ☐Penicillin ☐Sulfa ☐Local Anesthetic ☐Anti-inflammatory Medication ☐Codeine ☐Tape ☐Nausea From Anesthetic ☐Iodine on Skin ☐Latex ☐Other:_____

MEDICATIONS:

Medication	Dose	Medication	Dose

PREVIOUS SURGERY:

Surgery	Date	Surgery	Date

PREVIOUS HOSPITALIZATIONS:

Hospital	Date	Diagnosis

History Reviewed By/Dr. Signature:_____ Date:_____

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Reason For Seeing Doctor Today:_____

_____

_____

How would you describe your pain to the best of your ability?
(Circle All That Apply)

Burning Shooting Sharp Dull Aching Throbbing
Superficial Deep Tingling Other:_____

What makes the pain worse?

Walking Running Standing Sitting Shoe Gear
Barefoot Resting Other:_____

How long have you had the pain?

____Days ____Weeks ____Months ____Years

How long does the pain last when you have it?

Seconds Minutes Hours Chronic

Have you had any tramma? If yes please explain. Date:_____

No Yes_____

_____

PreviousTreatment:_____

_____

_____

Please Explain Your Condition Further If Necessary:_____

_____

_____

_____

History Reviewed By/Dr. Signature:_____ Date:_____

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