



Golden Gate Foot and Ankle Registration Form

Patient Information

Last Name: _____ First Name: _____
 Middle Initial: _____ Preferred Name: _____ DOB: ___/___/___
 Address: _____

City/State/Zip: _____

Height: _____' _____" Weight: _____ lbs. Shoe Size _____ Gender: _____

<p><u>Marital Status</u></p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p><u>Employment Status</u></p> <p><input type="checkbox"/> Employed</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Retired</p> <p><input type="checkbox"/> Student</p>	<p><u>Preferred Pharmacy:</u></p> <p>_____</p> <p>_____</p> <p><u>Primary Care Physician:</u></p> <p>_____</p> <p>_____</p>
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Contact Information

Cell Phone: (____)-____-____ Home Phone: (____)-____-____ Work Phone: (____)-____-____

Email: _____

Best Method of Contact: ___ Cell ___ Home ___ Work ___ Email

Reminder Preference: ___ Text ___ Call ___ Email

Emergency Contact Name : _____ Relationship: _____

Cell Phone: (____)-____-____ Home Phone: (____)-____-____

Insurance Information

I certify that I have coverage with _____ and assign directly to the physicians of Golden Gate Foot and Ankle all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The physicians of Golden Gate Foot and Ankle may use my health care information and may disclose such information to the aforementioned insurance providers, and their agents for the purpose of obtaining payments for services and determine insurance benefits or the benefits payable for related services.

Medical History

Please mark if you have been diagnosed with any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Cancer
<input type="checkbox"/> Circulatory Problems
<input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fainting
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other _____ |
|---|---|---|

Medications/Allergies

Medication Name	Dosage/Frequency	Mark if you are allergic to any of the following:
_____	_____	<input type="checkbox"/> Aspirin <input type="checkbox"/> Iodine <input type="checkbox"/> Seafood <input type="checkbox"/> Sulfa <input type="checkbox"/> penicillin <input type="checkbox"/> Lidocaine <input type="checkbox"/> Other _____
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Consent For Treatment

I hereby consent and give my permission to the physicians at Golden Gate Foot and Ankle to administer and perform such procedures upon me, as the doctor deems necessary.

Signature _____

Date ___/___/___