State of Franklin HEALTHCARE ASSOCIATES™

Patient Acct #: _____ Date: _____

Registration

Patient Name: _____ Sex: M / F Age: _____ D.O.B: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone Number: ( ) _____-_____

Mobile Telephone Number: ( ) _____-_____

E-mail: _____@_____

INSURANCE

PLEASE PROVIDE THE FRONT DESK WITH COPIES OF ALL INSURANCE CARDS

Primary Insurance Company: _____

Secondary Insurance Company: _____

Subscriber ID: _____ Group #: _____

Responsible Party Name: _____ D.O.B: _____

Relationship to Patient: _____ Phone: ( ) _____-_____

What is the reason for your visit today? _____

_____

_____

_____

Please list all allergies, both medication and environmental: _____

_____

_____

_____

Please provide us with a list of all your current medications, including dosages: _____

_____

_____

_____

_____

_____

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Please check the box next to any of the below symptoms that you are currently experiencing in your feet or ankles:

- ☐ Ingrown nail(s)
- ☐ Fungal nail(s)
- ☐ Numbness/tingling of feet/ankles
- ☐ Fractured bone in foot/ankle
- ☐ Foot/Ankle Sprain
- ☐ Heel Pain
- ☐ Calluses
- ☐ Corns
- ☐ Foot/Ankle Ulcers
- ☐ Warts
- ☐ Arch Pain
- ☐ Hammer Toe
- ☐ Mallet Toe
- ☐ Athlete's Foot

Have you ever been treated for any of the following? (Check all that apply)

- ☐ Flat Feet
- ☐ Trauma to feet or ankles
- ☐ Gait or walking/balance problems
- ☐ Broken bone in foot or ankle
- ☐ Pain in arches of feet
- ☐ Ulcers or sores of feet
- ☐ Bunions, calluses, or corns
- ☐ Stroke
- ☐ Phlebitis
- ☐ Vascular Disease
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Gout
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ None of the above

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Please list any previous surgeries or procedures on foot/ankle of concern: _____

_____

_____

_____

_____

_____

_____

Are you diabetic? ☐ Yes ☐ No

If yes, which provider is managing your diabetes? _____

What was your last Hgb A1C (if known)? _____