Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name		Last Name	
Sex	Marital Status	Date of Birth (Age)			
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Reason for Visit

What brings you to the office today?

Please describe any previous treatment and care you have received for this problem.

Pain Assessment

Indicate your level of pain on a scale of 1 - 10.
(10 = worst pain imaginable)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check the symptoms that best describe your problem.

☐ Stiffness ☐ Pain ☐ Instability ☐ Swelling
☐ Numbness ☐ Other: _____

Are your symptoms getting...

☐ Better Gradually ☐ Better Rapidly
☐ Worse Gradually ☐ Worse Rapidly

What improves your symptoms?

☐ Rest ☐ Ice ☐ Heat ☐ Motrin/ Aleve
☐ Other: _____

What makes your symptoms worse ?

☐ Activity ☐ Cold
☐ Other: _____

Podiatry

Do you have any of the following?

☐ Ankle Sprain	☐ Enlarged Veins	☐ Knee Pain
☐ Arch Pain	☐ Flat Feet	☐ Leg Ulcers
☐ Athlete's Foot	☐ Foot Numbness	☐ Loss of Sensation in Feet
☐ Broken Ankle	☐ Foot Ulcers	☐ Lower Back Pain
☐ Broken Foot Bones	☐ Fungal Nails	☐ Rash on Feet
☐ Bunions	☐ High Arch Feet	☐ Swelling in Ankles
☐ Burning in Feet	☐ Heel Pain	☐ Swelling in Feet
☐ Corns / Calluses	☐ Hammer Toes	☐ Swelling in Legs
☐ Cramps in Feet	☐ Ingrown Nails	☐ Tingling in Feet
☐ Cramps in Legs	☐ In-toeing	

Do you currently or have you ever worn orthotics?

☐ Yes ☐ No

Does your foot pain limit your desired activity?

☐ Yes ☐ No

Are your first steps out of bed in the morning painful?

☐ Yes ☐ No

Have you ever had any other foot problems?

☐ Yes ☐ No

If so, please describe: _____

Billing

Patient has Medicare? ☐ Yes ☐ No

Patient has Medicaid? ☐ Yes ☐ No

If yes, you will be asked to sign a paper acknowledging that you are aware that Dr. Costello does not accept Medicare or Medicaid and that you may not file a claim with Medicare or Medicaid for his services.

Name _____ Gender _____ Age _____

Date of Appointment: _____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

How many hours a day do you stand?

# of hours _____

What type of shoes do you wear?

☐ Flat ☐ Heels ☐ Boots ☐ Loafers ☐ Oxfords

☐ Sandals ☐ Sneakers Other: _____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex

☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine

☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Have you or any family member had a reaction to anesthesia? ☐ Yes ☐ No

Details: _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS/HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details: _____

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Past Medical History

Have you ever had any of the following?

☐ Alcoholism	☐ Back Problems	☐ Ear Problems	☐ Hepatitis - A, B, or C	☐ Measles	☐ Skin Disorder
☐ Allergies	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Blood Pressure	☐ Migraines	☐ Stomach Ulcer
☐ Anemia	☐ Blood Disease	☐ Epilepsy	☐ High Cholesterol	☐ Osteoporosis	☐ Substance Abuse
☐ Anxiety Disorder	☐ Blood Transfusion	☐ Glaucoma	☐ Joint Disorder	☐ Pneumonia	☐ Thyroid Disorder
☐ Arthritis	☐ Cancer	☐ Gout	☐ Kidney Disorder	☐ Polio	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Venereal Disease
☐ AIDS / HIV	☐ Depression	☐ Heart Problems	☐ Lung Disease	☐ Stroke	

COSTELLO
FOOT AND ANKLE CLINIC LLC

AUTHORIZATION FORM

Please read the following information carefully and sign at the bottom of the page to give consent.

Authorization for Treatment and Release of Protected Health Information

- I authorize the release of medical information to Costello Foot and Ankle Clinic and all providers under contract with Costello Foot and Ankle Clinic.
- I authorize Costello Foot and Ankle Clinic to treat and perform procedures that may be necessary as deemed by the treating provider.
- I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse - to include alcohol & drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Costello Foot and Ankle Clinic.

Notice of Privacy Practices Acknowledgment

- Notice of Privacy Practices provides information about how Costello Foot and Ankle Clinic may use and disclose protected health information about our patients. By signing this form you have acknowledged the receipt and opportunity to read the notice of privacy practices of Costello Foot and Ankle Clinic. You may access a copy of the notice at our office or by visiting our website at www.costellofootandankle.com
- You have the right to request restrictions on how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
- By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice.

Patient Financial Policy

- Payment for office services are due at the time of service.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

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

Print Name of Patient/Responsible Party: _____