Patient Registration Form

Last Name: First Name: Middle Initial:

Birth Date: / / Age: Marital Status: Sex:

Address: City: State:

Home Phone: ( ) - Cell Phone: ( ) - Zip:

Work Phone: ( ) - Employer:

Social Security #: - - Occupation:

Email Address:

Emergency Contact: Relationship:

Parent or Gardian's Name (if minor): Phone #: ( ) -

Primary Insurance:

Secondary Insurance:

Medical History

Family Physician:

Did anyone refer you to us? Who?

What problem brings you in today?

Shoe Size: Height: Weight: **Lbs**

Do You Smoke? How Much? Time(s) per

Do You Drink? How Much? Time(s) per

Past Medical History ✔ (***Check*** *all that apply*):

- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Bleeding Problem**
- ☐ **Blood Clot**
- ☐ **Cancer**
- ☐ **Cholesterol**
- ☐ **Circulation Problem**
- ☐ **Diabetes**
- ☐ **Gout**
- ☐ **Headaches**
- ☐ **Hearing Problems**
- ☐ **Heart Attack**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **HIV Positive**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Lung Disease / Asthma**
- ☐ **Peptic Ulcer / Acid Reflux**
- ☐ **Stroke**
- ☐ **Thyroid**
- ☐ **Vision Problem**
- ☐ **Other:**

List all medications you take:

List all allergies you have:

List all operations or serious injuries you have had:

Does anyone in your family have? ✔ (***Check*** *all that apply*):

- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Heart Trouble**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Stroke**

For Women Only : Are You Pregnant? How many months?

Patient Signature: Date:

SEE BACK----->

Acknowledgement of Receipt Of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Financial Policy

I hereby authorize Victor R. Aybar, D.P.M. to apply for benefits on my behalf for covered services rendered by him. I request payment from my insurance company to be made directly to Victor R. Aybar, D.P.M. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at anytime in writing. I understand that nothing herein relieves me of this primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

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Patient Name (PRINT)

Parent or Authorized Representative

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Signature

____

Date