ROCHE PODIATRY GROUP
PATIENT REGISTRATION FORM

This information is confidential

PATIENT INFORMATION

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____)_____

Cell Phone(_____)_____

E-mail:_____

Social Security #_____

Primary Physician_____

Address _____

City_____ State_____

Phone Number _____

Date Last seen_____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian

☐ Hispanic Latino ☐ Other

Language Spoken_____

Date of Birth_____

Occupation _____

Employer _____

Address _____

_____

Work Phone (____)_____Ext_____

INSURANCE INFORMATION

Primary Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse ☐ Parent

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse ☐ Parent

PHARMACY INFORMATION

Pharmacy Name_____

Address_____

City_____ State_____

Phone Number_____

EMERGENCY CONTACT

Name_____

Relationship: _____

Telephone (____)_____

Work Phone(____)_____Ext_____

ROCHE PODIATRY GROUP
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Is your treatment today due to:

……..a work related injury? ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated? ☐ Yes ☐ No

……..a motor vehicle accident? ☐ Yes ☐ No Accident Date_____

…… an accident/liability case? ☐ Yes ☐ No Accident Date_____

Whom may we thank for sending you to our office?

☐ Doctor_____

☐ Patient_____

☐ Newspaper_____

☐ Other_____

☐ Verizon Yellow Pages ☐ Website

☐ The Yellow Book

☐ Insurance Provider List

☐ Passed by Location ☐ Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X_____ Date_____

MEDICARE SIGNATURE ON FILE (If Applicable)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **ROCHE PODIATRY GROUP** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)	**PROVIDER: Name, Address, and Zip**
	ROCHE PODIATRY GROUP **4 Progress Street** **1000 RT 9N** **Edison, NJ 08820** **Woodbridge, NJ 07095** **3895 RT 516** **Old Bridge, NJ 08857**
PATIENT'S SIGNATURE	

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

   _____

2. **When did pain/discomfort begin (date):** _____

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ No ☐ Yes _____

5. **Have you had an accident?** ☐ No ☐ Yes _____

6. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Thyroid Disorders	☐ Osteoarthritis
☐ Asthma	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Bleeding Disorders	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Cancer _____	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Diabetes	☐ HIV / AIDS	☐ Neurological Disorders	☐ Kidney Disease
☐ Epilepsy	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: _____

7. **List all medications/herbs/vitamins:** ☐ **NONE** _____

   _____

8. **Allergies:** (Describe reaction) ☐ **NONE**

   ☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
   ☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
   ☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
   ☐ Other _____

9. **Are you currently pregnant?** ☐ No ☐ Yes _____

10. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

    Surgery / Date: _____

    _____

11. **Social History:** (Only check what is pertinent to you)

    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
    ☐ Caffeine Use ☐ Drug use (recreational, IV)

12. **Family History: (List relationship of family member(s) who have had these problems):**

    ☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____
    ☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
    ☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
    ☐ Other family History: _____

13. **Height:** _____ **Weight:** _____ **Shoe size:** _____

FOR OFFICE USE: B/P _____ **PULSE** _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	