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:_____

Marital Status	Employment Status	Preferred Pharmacy:
☐ Single	☐ Employed	_____
☐ Married	☐ Unemployed	_____
☐ Divorced	☐ Retired	Primary Care Physician:
☐ Widowed	☐ Student	_____
		_____

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:

☐ AIDS/HIV	☐ Epilepsy	☐ Kidney Problems
☐ Arthritis	☐ Fainting	☐ Liver Problems
☐ Bleeding Disorders	☐ Gout	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Tuberculosis
☐ Circulatory Problems	☐ Hepatitis	☐ Other _____
☐ Diabetes	☐ High Blood Pressure	

Medications/Allergies

Medication Name	Dosage/Frequency		Mark if you are allergic to any of the following:
_____	_____		__ Aspirin
_____	_____		__ Iodine
_____	_____		__ Seafood
_____	_____		__ Sulfa
_____	_____		__ penicillin
_____	_____		__ Lidocaine
			__ 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 ____/____/_____

Provider Signature:_____