# PATIENT REGISTRATION & HISTORY FORM
## DR. STEVE MARKANTONE

**PATIENT INFORMATION** Date ______/______/________

Patient Name ____________________________________________
First Last M.I.

Address ____________________________________________
Street

____________________________________________
City State ZipCode

Male_____ Female_____ / Age______ Date of Birth ______/______/________
Marital Status Single ___ Married ___ Widowed ___ Divorced ___
Height __________ Weight __________ Shoe Size __________
Patient SS# _______/_______/_______ Occupation ______________________
Employer______________________ Address ______________________
Phone# ______________________
Spouse's Name ______________________ Date of Birth ______/______/________
Spouse's SS# _______/_______/_______
Spouse's Employer ______________________ / Occupation ______________________

Home Phone# ( ) _______- _______ Work Phone# ( ) _______ - ________
Cell Phone# ( ) _______- _______

Whom may we thank for referring you? ______________________

**Email Address** ______________________
IN CASE OF AN EMERGENCY, CONTACT
Name ______________________ Relationship ______________________

Home Phone# ( ) _______ - _______ Work Phone ( ) _______ - ________

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**INSURANCE**
**Who is responsible for this account?** ______________________
**ASSIGNMENT AND RELESE**
I, the undersigned certify that I or my dependent) have insurance coverage with ____________________________
and assign directly to Dr. Markantone all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ / ____________________
Responsible Party Signature Date

**MEDICARE AUTHORIZATION**
I request that payment of authorized Medicare benefits be made either to me or on my behalf of Dr. Markantone for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for 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 physician or supplier agrees to accept the change 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.

______________________________ / ____________________
Beneficiary Signature Date

# MEDICAL HISTORY

Please mark the boxes below "Yes" or "No" if you have any of the following:

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No |
| Allergies to Anesthetics | ☐ Yes | ☐ No | Ear Problem | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No |
| Allergies to Medicine or Drugs | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| | | | Eye Problems | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Foot or Leg Cramps | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Artificial Heat Valves Or Joints | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| | | | Heart Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Swelling in Ankles/Feet | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Hepatitis or Jaundice | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Tired Feet | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Nervous Problems | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss(unexplained) | ☐ Yes | ☐ No |
| | | | | | | Are You Pregnant? | ☐ Yes | ☐ No |

List Surgeries you have had______________________________________________________________

_________________________________________________________________________________

Hospitalization other than surgeries listed above____________________________________________

_________________________________________________________________________________

List any known Allergies ___________________________________________________________

Please list all medications which you now use: ________________________________________

_________________________________________________________________________________

Pharmacy Name _____________________________ Pharmacy Phone # (       ) _______ - ________

Family Physician___________________________________ Date Last Seen______/______/________

Are you now, or have you been, under any other doctor's care for any reason over the past two years?
☐ Yes ☐ No
If Yes, please explain______________________________________________________________

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of me.

Patient's Signature _________________________________________ Date______/______/________

Guardian's Signature (if under 18 yrs. of age)______________________________________________

# PODIATRY HISTORY

1. What problems bring you to our office?________________________________________________

2. Indicate which of your immediate relatives have had any of the following diseases:

| | | | |
|---|---|---|---|
| Cancer | ☐ | Diabetes | ☐ |
| Heart Trouble | ☐ | High Blood Pressure | ☐ |
| Kidney Disease | ☐ | Mental/Emotional Disease | ☐ |
| Stroke | ☐ | Arthritis | ☐ |

| YES | NO | Nature of Problem – Podiatric | Comments and Give Approximate Date |
|---|---|---|---|
| | | Has anyone in your family ever had foot problems similar to yours? | |
| | | Do you spend more than 50% of your working day standing? | |
| | | How long have you had your symptoms? | |
| | | Are your symptoms worse after standing? | |
| | | Are your symptoms worse after walking? | |
| | | Are your symptoms worse after wearing shoes? | |
| | | Do your symptoms affect your work or sports activities? | |
| | | Are your required to wear special foot gear? | |
| | | What exercise do you do at home? How often? | |
| | | Have you tried home remedies or self treatment? Please describe. | |
| | | Have you been treated by a doctor for your foot condition? Please describe. | |
| | | Pain in feet or legs? | |
| | | Cramping in feet or legs? | |
| | | Burning in feet or legs? | |
| | | Tingling in feet or legs? | |
| | | Redness / discoloration in feet or legs? | |
| | | Swelling in feet or legs? | |
| | | Itching in feet? | |
| | | Corns? | |
| | | Calluses? | |
| | | Numbness in feet or legs? | |

Former Podiatrist:________________________________________________________________________

Name

Why & When did you last see a podiatrist?___________________________________________________

_________________________________________________________________________________________

Patient's Signature_____________________________________________Date______/______/________