WILLIAM H. DICKIESON, D.P.M., P.C. Registration Information

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Patient's Full Name_____ **Date**_____

Address_____ **CITY**_____ **STATE**_____ **ZIP**_____

Phone_____ **Date Of Birth**_____ **Age**_____ **Martial Status S M D W**

Patient's Social Security_____ **Sex M F Height**_____ **Weight**_____ **Shoe Size**_____

E-Mail address (to be used only for general contact) _____

Patient's Occupation_____ **Employer**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Name of Person Responsible for Bills**_____

Relation To Patient_____ **Social Security#**_____

Employer_____ **Phone**_____

Address If Different Than Patient's_____

Patient's Physician (required for billing) _____ **Phone**_____

Name of Patient's Pharmacy_____ **Phone**_____

Referred To Our Office By_____

INSURANCE INFORMATION-PLEASE PRESENT YOUR INSURANCE CARDS AT THE FRONT DESK

Name Of Insurance _____ **Medicare #**_____

Subscriber Name _____ **Date Of Birth** _____

Contract #_____ **Group #** _____

Other Insurance _____

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO THE DOCTOR FOR ANY SERVICES THAT I RECEIVE **Signature**_____ **Date**_____

IN THE EVENT OF NON-PAYMENT OR DEDUCTABLES, I ACCEPT FULL RESPONSIBILITY-

Signature_____ **Date**_____

RACE: Required by Medicare (please Circle one)

American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other:

Preferred Language: Required by Medicare

English/Spanish/Other: _____

Ethnicity: Required by Medicare

Cuban/Hispanic or Latino/Mexican/Puerto Rican

Not Hispanic or Latino

PATIENT'S MEDICAL HISTORY (please circle)

Diabetes	Y	N
High Blood Pressure	Y	N
Heart Disease	Y	N
Arthritis	Y	N
Asthma	Y	N
Dementia	Y	N
Anemia	Y	N
Kidney Disease	Y	N

ALLERGIES TO MEDICATION (please circle)

Penicillin	Y	N
Aspirin	Y	N
Codeine	Y	N
Adhesive Tape	Y	N
Latex	Y	N
Sulfa	Y	N
Iodine	Y	N

Other: _____

SOCIAL HISTORY

Smoker Yes No Quit If yes, how long: _____ If quit, how long ago: _____
packs/day_____

Alcohol consumption_____/ day week month none

PLEASE BE SPECIFIC IN ANSWERING THE FOLLOWING QUESTIONS

What is your foot problem? _____

_____

When did this problem start? _____

Have you had foot treatment before? _____

Please list medications you are currently taking or present a list of medications to front desk:

_____

_____

_____

FAMILY HISTORY

Father's date of birth_____

Is father Alive ( ) or Deceased ( )

If father is Deceased, When did he die? _____

Cause of Death_____

How old was your father when he deceased? _____

If father is Alive what is his illness or condition_____

_____

Mother's date of birth _____

Is mother Alive ( ) or Deceased ( )

If mother is Deceased, When did she die? _____

Cause of Death _____

How old was your mother when she deceased?_____

If mother is Alive what is her illness or condition _____

_____