KEYSTONE PODIATRIC MEDICAL ASSOCIATES, P.C.

REGISTRATION FORM

(Please Print) #_____

Primary Care Physician:	Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:			Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Home phone number	Cell phone number	Spouse's name	Pt's Birth date:	Age:	Sex:	
( )	( )		/ /		❑ M	❑ F

Patient's Email address:	Emergency contact	Emergency contact's number
		( )
Patient's employer	**Patient's work address**	**Patient's work number** ( )

I chose KPMA because / I was referred to KPMA by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:				

What is the main problem you are having with your feet?	DESCRIBE:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO			YES	NO
Arthritis				Heart disease		
Asthma				Hepatitis		
Bleeding disorder				Hypertension		
Cancer				Kidney disease		
Circulatory disorders				Liver disease		
Diabetes				Phlebitis		
Gout				Stomach Ulcer		
HIV infection				Previous foot pain? explain		
other				History of substance abuse?		

HAVE YOU HAD ANY SURGERY? ❑ YES ❑ NO	DESCRIBE:

ARE YOU ALLERGIC OR SENSITIVE TO

	YES	NO			YES	NO
Novocaine				Food		
Penicillin				Anesthetics		
Adhesive tape				Latex		
Materials				Other (describe)		
Drugs						

Are you a smoker? Yes No If you quit, when? _____	How much?	Have you ever smoked? Yes No
What is your weight?	What is your height? Ft. inches	What is your shoe size?