

**Dr. Lonnie N. Resnick
East Avenue Podiatry
Patient Registration Form**

Patient Name _____ Birthdate _____
(Last) (First)

Street Address _____

City/State: _____ Zip Code: _____

Home # _____ Work # _____ Mobile # _____

Email Address: _____

Sex (Circle) Male Female Marital Status (Circle) M S D

Patient SSN # _____ Name of Spouse/Parent _____

Patient's Employer: _____

Employer Address: _____

Primary Care Physician: _____

Primary Care Physician's Address : _____

Emergency Contact Name: _____ Phone # _____

Who may we thank for this referral? _____

Patient History

Chief complaint today: _____

May we contact your physician for your health records if necessary? Yes No

May we share our findings with your physician? Yes No

Are you presently pregnant? Yes No Breastfeeding? Yes No

What medications do you take regularly? _____

Do you have any allergies? _____

What was the reaction? _____

Have you had any past surgeries or hospitalizations? _____

Social History: Tobacco _____ Alcohol _____ Recreational Drugs _____ How often _____

Family History: Heart problems Stroke Diabetes Gout Arthritis Cancer

Do you have or have you had any of the following? Please circle any/all that apply:

- | | | | |
|-------------------|-------------------|---------------------|-------------------|
| Arch or Heel Pain | Asthma | Arthritis | Bleeding Problems |
| Bunions | Cancer | Circulation issues | Diabetes |
| Foot/leg cramps | Foot/Leg injuries | Foot/leg numbness | Gout |
| Heart trouble | Hepatitis | High blood pressure | Kidney disease |
| Liver disease | Low back pain | Prone to infection | Skin problems |
| Stomach ulcers | Toenail problems | Weak ankles | Numbness in Feet |
| Painful toes | | | |

Other: _____

I authorize the release of any medical information needed to process this claim and authorize payment to myself or my provider for services rendered. I understand that according to medicare and other insurance policies, patients are sometimes responsible for the deductible amount, co-insurance amount and any non-covered services.

Signature: _____

Date: _____