RICHARD M. ALLEN DPM

REGISTRATION FORM

PHARMACY:

Today's date:	**Primary Dr.**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Weight:	Height:	Shoe size:
Race: (circle one) American Indian or Alaska Native/ Asian/ African American/ Caucasian/ Hispanic	Email Address:	
Street address: Cell Phone:	Social Security no.:	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance:	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Richard Allen or insurance company to release any information required to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Patient/Guardian signature *Date*

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO PAST MEDICAL HISTORY:

AIDS/HIV	Crohn's Disease	Left Ventricular Systolic
Alcoholism	Diabetes, Type 1 or 2	Lupus
Allergies	Dizziness/fainting	Lymphedema
Angina	Depression	DVT
Arthritis	Dementia	Measles
Aortic Aneurysm	Edema	Multiple Sclerosis
Appendicitis	Emphysema	Mumps
Arteriosclerosis	Epilepsy	Murmur
Asthma	Femoral Popliteal Bypass	Myocardial infarction
Bipolar	Gangrene	OCD
Birth Trauma	Goiter	Osteoporosis
Bronchitis	GERD	Pacemaker
Cancer_______________________	Phlebitis	Cardiac Arrest
Gout	Pleurisy	Cardiac Arrhythmias
Hepatitis A, B, C	Pneumonia	Cardiac Disease
Hernia	Polio	Cardiomyopathy
Herpes	Peripheral Vascular Disease	Celiac Disease
Hyperlipidemia	Chicken Pox	Hypertension
Rheumatic Fever	Chronic Heart Disease	Hypotension
Rheumatic Heart Disease	Claudication	Irritable Bowel Syndrome
Scarlet Fever	Congestive Heart Failure	Kidney Problems
Seizures	Stroke	Thrombophlebitis
Thyroid Disorder	Tuberculosis	Typhoid Fever
Ulcers	Varicose Veins	Venereal Disease
Weight Change	Whooping Cough	Other__________________

PLEASE CIRCLE ANY THAT APPLYS TO FAMILY HISTORY:

Acne	Acute Rheumatic Fever	ADHD
Age Related Macular Degeneration	Allergy	Angina
Ankylosing Spondylitis	Arthritis	Atherosclerosis
Autism	Bipolar Disorder	Cancer_________________
Cardiovascular	Disease	Celiac Disease
Colorectal Polyps	Congenital Conditions	Coronary Heart Disease
Crohn's Disease	Cyclic Vomiting Syndrome	Dementia
Depression	Diabetes	Diabetes-Type 1
Diabetes-Type 2	Duodenal Ulcer	Eczema
Emphysema	End-Stage Renal Disease	Familial Emphysema
Genetic Disease	Gestational Diabetes	Glaucoma
Heart Attack	Heart Disease	Heart Failure
Hemochromatosis	Hepatoma	High Cholesterol
Hodgkin's Disease	Hypertension	Hyperthyroidism
Hypertrophic Cardiomyopathy		

FAMILY HISTORY CONTI NUE:

Kidney Stones	Liver Cancer	Melanoma
Migraine	Narcolepsy	OCD
OCPD	Osteoarthritis	Osteoporosis
Pancreatic Cancer	Presbycusis	Pri. Pulmonary Hypertension
Prostate Cancer	Psoriasis	Rheumatic Fever
Rheumatoid Arthritis	Rosacea	Schizophrenia
Scoliosis	SIDS	Stroke
Thyroid Cancer	Uterine Cancer	Vaginal Cancer
Varicose Vein	Vertigo	

PLEASE CIRCLE ALL THAT APPLYS TO PAST SURGERY HISTORY:

Abdominal Surgery	ACL Reconstruction	Amputation of Extremity
Amputation of Foot	Amputation of Toe	Angioplasty
Ankle Surgery	Appendectomy	Artificial Joint Replacement
Back Surgery	Biopsy	Bladder Suspension
Bowel Surgery	Brain Surgery	Breast Augmentation
Breast Reduction	Breast Surgery	Breast Tumor Removal
Bunionectomy	Cardiac Catheterization	Carpal Tunnel Surgery
Cataract Extraction	Cervix Surgery	Cholecystectomy
Colectomy	Colon Resection	Colon Surgery
Coronary Artery Bypass Graft	Craniotomy	C-Section
Cyst Removal	D&C	Discectomy
Ear Surgery	Ear Tubes	Esophageal Surgery
Eye Surgery	Foot Surgery	Ganglion Cyst Removal
Gastrostomy	Gastric Endoscopy	Hammertoe Surgery
Hand/Wrist Surgery	Head/Neck Surgery	Hemorrhoidectomy
Hernia Repair	Hip Replacement	Hysterectomy
Jaw Surgery	Kidney Stone Removal	Kidney Surgery
Knee Surgery	Lasik Eye Surgery	Liposuction
Mandibular Osteotomy	Mastectomy	Mastoidectomy
MCL Repair	Nail Removal	Nephrectomy
Neuroma Surgery	Oral Surgery	Organ Transplant
ORIF	Ovarian Surgery	Pacemaker Implant
Parathyroid Surgery	Plantar Wart Removal	Polyectomy
Prostate Cryotherapy	Prostate Surgery	Pyloroplasty
Rectal Surgery	Septoplasty	Spinal Fusion
Stent Insertion	Thoracotomy	Thyroidectomy
Tonsillectomy	Tonsilloadenoidectomy	Tubal Ligation
Upper Extremity Surgery	Valve Surgery	Vascular Surgery
Vasectomy	Vein Stripping	Wart Removal
Whipple Procedure	Wisdom Teeth Removal	

Other____

PLEASE CIRCLE ANY MEDICATION YOU ARE ALLERGIC TO:

Local Anesthetic (novocaine)   Darvon   Codeine   Sulfa Drugs
Demerol   Iodine   Penicillin   Aspirin   Adhesive Tape

Type of reaction:____

List any other medication you are allergic to that is not listed above ________________________
____

Non-Smoker______________________   Smoker______________   How many yrs.?_____________________

Are you currently taking any medication? ________ If so, please record the name, dosage, instruction and condition being treated or provide a list: ____
____
____

WHAT WOULD YOU LIKE DR. ALLEN TO LOOK AT TODAY? ____________________________________
____

HOW LONG HAS THIS PROBLEM EXISTED? ____
____

HAVE YOU SEEN ANOTHER DR. FOR THIS PROBLEM? IF SO WHO? ______________________________
____

WHAT TREATMENTS WERE RENDERED? ____
____
____

PLEASE READ AND SIGN BELOW

I understand that patients without insurance coverage are expected to pay for services after each visit. I understand that if my account is in default and is sent to a collection agency, I will be responsible for any collection fees that may apply.

______________________   ____
DATE   SIGNATURE (patient or parent, if minor)

I hereby authorize payment by my insurance company directly to Dr. Allen of surgical or medical benefits. I understand that if my account is in default and is sent to a collections agency, I will be responsible for any collections fees that may apply.

______________________   ____
DATE   SIGNATURE (patient or parent, if minor)

*****PLEASE NOTE THAT IF THIS PATIENT INFORMATION SHEET IS NOT FILLED OUT AT TIME OF APPOINTMENT WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT FOR A LATER DATE*****