Patient Registration Form

Office of Jeffrey V. Chou, DPM

First Name_____M.I._____ Last Name_____

Street Address_____ Apt #_____ City_____

State_____ Zip Code_____ SSN# _____

Home Phone # ( )_____ Cell# ( )_____ Work# ( )_____

Gender: Male or Female Date of Birth _____/_____/_____ Marital Status_____

Race_____ Ethnicity_____ Language_____

Email Address_____ Employer_____

Primary Care Provider_____ Phone# _____

Pharmacy of Choice_____ Phone# _____

Pharmacy Address (if known) _____

How did you hear about us? _____ Dr's Name that referred you_____

Emergency Contact_____ Phone# ( )_____ Relationship_____

Financially Responsible Persons First Name_____ Last_____

Gender: Male or Female Date of Birth_____/_____/_____

Street Address_____ City_____ State_____ ZIP_____

Home# ( )_____ Work# ( )_____ Cell# ( )_____

Patients authorization and Assignment of Benefits: I hereby authorize the processing of the medical insurance either by electronic or manual method by Jeffrey V. Chou DPM. My signature authorizes payment for all major medical and or durable medical equipment supplies and or surgical benefits to which I am entitled by the insurance card provided to the office to pay for services rendered to Jeffrey V. Chou DPM. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I grant permission to contact me via email. I permit a copy of the authorization to be used in place of original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of Responsible Party_____ Date_____

Relationship (if not patient) _____

Medical History Form

Office of Jeffrey V. Chou, DPM

First Name _____ M.I._____ Last Name_____

Date of Birth _____ Height,m _____ Weight

_____

Most Current Blood Pressure _____ Date of Last Flu Shot _____

Where did you receive the flu shot?_____ Date of Last Pneumonia Shot _____

What brings you into the office today?

_____

_____

When does this problem occur?

_____

Any previous treatments for the issue? (Either prescribed or Home Remedies)

_____

Is it a work-related injury? _____ If Yes, date of injury? _____

List any current sports / activities _____

Are you on a blood thinner? _____ If so WHY ?_____

List below or attach a current list of medications (prescription and over-the-counter)?

_____

_____

_____

Allergies? _____

Please list hospitalizations:

_____

_____

Medical History (Please Circle All That Apply)

Alcohol/Drug addiction
Alzheimers/Dementia
Anemia - Type _____
Arrhythmias - Type _____
Arthritis
Asthma
Bleeding/Clotting problem
Cancer-Type _____
Depression / Anxiety / Bipolar
Diabetes: Insulin Dependent or Non Insulin Dependent
How long? (years)_____
Last A1C_____
Last FBS_____
Emphysema/COPD
GERD (Reflux)
GI ulcers
Gout
Headaches / Migraines
Heart Disease
Hepatitis A B or C/Liver Disease
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney/Renal Failure
Lung Disease/Pulmonary Embolus
Osteoporosis/Osteopenia
Phlebitis (blood clots in legs)
Pregnancy- If yes, due date_____
Poor Circulation/PVD
Seizures/Epilepsy
Sickle Cell Trait/Disease
Thyroid Problems

Please list other medical problems not listed:

_____

Surgical History (List surgeries you have had in the last 7 years):

_____

CIGARETTE SMOKING: (circle) 1. Never Smoked 2. Quit: former smoker 3. Smokes less than daily
4. Smokes daily – if yes, how many? _____

ALCOHOL: YES or NO If YES, how many drinks consumed in a day? _____ Week? _____

Do you or have you used illicit/recreational drugs? YES or NO If yes which ones_____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any questions on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Jeffrey V. Chou, DPM to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Jeffrey V. Chou, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party _____ Date _____

Relationship (if not Patient) _____