

North Carolina Orthopaedic Clinic

Patient Registration Form

FOR US TO PROCESS YOUR CHART, PLEASE COMPLETE FULLY AND PRINT CLEARLY

PATIENT INFORMATION

NAME: _____

TODAY'S DATE: _____

BIRTHDATE: _____ AGE: _____

SOCIAL SECURITY #: _____

ADDRESS: _____

OCCUPATION: _____

CITY STATE ZIP

EMPLOYER: _____

PHONE #: _____

WORK PHONE #: _____

CELL PHONE #: _____

SPOUSE/PARENT: _____

INSURANCE PRIMARY: _____

SUBSCRIBER: _____

SECONDARY: _____

SUBSCRIBER: _____

OTHER INSURANCE: _____

SUBSCRIBER: _____

PRIMARY CARE DOCTOR: _____

I don't have one

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____

REFERRING HEALTHCARE PROFESSIONAL: _____

(MD, PT, Chiropractor, etc.)

No one referred me

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____

PREFERRED PHARMACY: _____

I don't have a pharmacy preference

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

Who is your appointment with today?

Dr. Almekinders

Dr. Minchew

Dr. Parekh

Dr. Tawney

Dr. Schreyack

Dr. Richard

I give permission for my physician to access my medication history from the National Surescripts Database.

Sign _____ Date _____

Patient Medical History

Name _____ Date _____ DOB _____ MRN _____
Age _____ Height _____ Weight _____ Shoe Size _____

Referred by: Self _____ Doctor _____ Friend _____

Please describe your chief foot complaint _____

How long have you had this problem _____ Is your problem injury related? If so, date of injury _____

Please rate your foot pain today. No Pain __1__2__3__4__5__6__7__8__9__10 Very Bad Pain
Describe your pain: __Occasional__ Constant/Continuous __Aching__ Sharp __Tender__ Burning __Radiating__
What relieves your foot pain? _____

Have you received prior treatment for this problem? (Check all that apply)

- No prior treatment Self treatment Anti-Inflammatory Surgery Orthotics/Insoles
- Over the counter products Treatment by Dr. _____

Past Medical History (Do you have any of the following conditions?)

- Alzheimer’s disease Circulatory Problems High Blood Pressure Rheumatic Fever
- HIV positive Seizures Liver Problems Diabetes (# _____ yrs)
- Back Problems Asthma/Bronchitis Foot/Leg Cramps GI Bleeding
- Cancer Sickle Cell Anemia Mitral Valve Prolapse Bleeding Disorders
- Numbness in Feet Gout Blood Clots Heart Disease
- Phlebitis Tuberculosis Hepatitis Stroke
- Arthritis Ulcers, GI Previous Drug Abuse Other _____

Past Surgical History None

_____ Date _____ _____ Date _____
_____ Date _____ _____ Date _____

Do you have any artificial implants? (artificial joints, pins, screws, etc.) If so, please explain _____

Medications: Please list all medications that you now take, including over the counter medications.

Allergies: Please check any allergies you may have below:

- No Allergies Aspirin Penicillin Adhesive Tape Codeine
- Sulfa Antibiotics Local Anesthetics Other _____

Family Medical History:

- Bleeding Disorder Cancer Circulatory Problems Diabetes mellitus
- Gout Heart Disease Hypertension Other _____

Social History: Married Single Widowed Divorced Separated Domestic Partner

Occupation _____ How Long? _____

Tobacco Use _____ (pks /day) Alcohol _____ (drinks/day)

Do you or have you used recreational drugs or IV drugs? If so, please explain _____

Additional notes or Comments that you would like the doctor to know: _____
