FOOT AND ANKLE CLINIC OF SPOKANE, INC.
JACQUELINE BABOL, DPM

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy)	Sex ☐M ☐ F	Spouse's Name
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	EMail		Mobile Phone # ( )
Employer	Employer Address		Employer/Work Phone # ( )
Pharmacy Name & Phone #	Primary Care Physician (PCP)		Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex ☐M ☐ F	Relationship to Patient ☐ Self ☐Spouse ☐ Child ☐ Other
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	EMail		Mobile Phone # ( )
Employer	Employer Address		Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	CoPayment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	CoPayment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ☐ Dr. ☐ Hospital/ER ☐ Lecture ☐ Insurance Plan

☐Phonebook ☐Internet ☐Website ☐ Friend/Family: _____ ☐ Other: _____

The above information is true to the best of my knowledge.I certify that I have insurance with the insurance company(ies) disclosed and assign directly to the Foot & Ankle Clinic/ Dr. Jacqueline Babol DPM all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submission. FACS may use my health care information and may disclose such information to the disclosed insurance companies and their agents. I have been given a copy of the Privacy Policies of this Facility.

PAYMENT DUE AT TIME OF SERVICE: I agree to pay my unmet deductible.copay, estimated coinsurance today and each visit. I hereby authorize charging my credit card for☐ all of today's charges including deductible/copay/coinsurance ☐ all future visits' coinsurance

V/MC Number_____exp_____

X_____

PATIENT/GUARDIAN SIGNATURE PRINT NAME RELATIONSHIP TO PATIENT DATE

FOOT AND ANKLE CLINIC OF SPOKANE, INC.
JACQUELINE BABOL, DPM

COMPREHENSIVE HEALTH REVIEW

Patient Name:_____ Date of Birth:_____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

Which foot/ankle is involved? □ Right □ Left □ Both

First visit to a doctor for this problem? □ Yes □ No

Have you had a similar problem in the past? □ Yes □ No

When did the problem begin? _____

How was the problem onset? □ Sudden □ Gradual

The problem is: □ Improving □ Worsening □ Unchanged

The problem is worst: □ AM □ PM □ At Rest □ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? □ Yes □ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: □ Sharp □ Dull □ Aching □ Throbbing □ Cramping □ Itching □ Popping
□ Burning □ Tingling □ Clicking □ Shooting □ Stabbing □ Other: _____

Describe previous treatments: _____

Is this from an injury? □ Yes □ No If so, is it work related? □ Yes □ No _____

PAST MEDICAL HISTORY

□ Diabetes Type 1 2 Duration_____years Last Blood Sugar_____HbA1c_____
□ Acid Reflux
□ Anemia
□ Anesthesia Complications
□ Arthritis (□ Osteo / □ Rheum)
□ Asthma
□ Back Problems/Sciatica
□ Blood Clot/DVT
□ Cancer:_____
□ Cellulitis/Skin Infection (□ MRSA?)
□ Circulation Problem
□ Dementia/Alzheimer's
□ Excessive/Easy Bleeding
□ Fibromyalgia
□ Foot/Leg Ulcer
□ Gout
□ Healing Problems/Keloids
□ Heart Disease/Heart Attack
□ High Blood Pressure (□ Low BP?)
□ High Cholesterol
□ Hormone Therapy
□ Immune Disorder/HIV
□ Kidney Disease (□ Dialysis)
□ Liver Disease (□ Hepatitis)
□ Leg Cramps/Leg Pain at Rest
□ Lung Condition:_____
□ Mitral Valve Prolapse/Murmur
□ Multiple Sclerosis
□ Nervous Disorder/Depression
□ Neuropathy
□ Osteomyelitis/Bone Infection
□ Parkinson's Disease
□ Previous Addiction to:_____
□ Pulmonary Embolism
□ Rashes/Skin Condition
□ Raynauds Disease/Phenomena
□ Seizure Disorder/Epilepsy
□ Sickle Cell Disease/Trait
□ Sleep Apnea
□ Stomach Ulcers
□ Stroke □ Rt □ Lt (year_____)
□ Thyroid Condition (□ Hi □ Lo)
□ Varicose Veins
□ Women – Are You Pregnant or Breast Feeding?
□ Other problems not listed: _____

PAST SURGERIES

□ Foot/Ankle Surgery: _____
□ Joint Replacement: _____
□ Open Heart/Bypass Surgery
□ Hysterectomy □ Tubal ligation □ CN Section
□ Stent Placement: Heart Leg
□ Cosmetic Surgery: _____
□ Appendix □ Gallbladder □ Tonsils/Add
□ Leg Bypass □ Open Fracture Repair
□ Carotid Surgery □ Vein Surgery
□ Hernia repair □ Thyroid □ Back surgery
□ Other: _____

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

□ Cancer	M F S B GP
□ Diabetes	M F S B GP
□ Gout	M F S B GP
□ Heart Disease	M F S B GP
□ High Blood Pressure	M F S B GP
□ Severe Arthritis	M F S B GP
□ Anesthesia Complications	M F S B GP
□ Foot Problems	M F S B GP
□ Other: _____	M F S B GP

COMPREHENSIVE HEALTH REVIEW

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ☐ **None**
- ☐ Adhesives/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine
- ☐ Latex
- ☐ LocalAnesthetics
- ☐ Penicillin
- ☐ Seafood/Shellfish
- ☐ Sulfa Drugs
- ☐ _____

SOCIAL HISTORY

Occupation: _____

☐ I Drink Alcoholic Beverages How much/often? _____

☐ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

☐ I Use or Have Used Drugs that are Illegal _____

I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand _____% of My Day

I Exercise Each Week: ☐ 0 days ☐ 1L2 days ☐ 3+ days

List Sports/Activities: _____

_____

☐ My foot/ankle problem limits my activities

I am: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Changes
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue

EYES
- ☐ Eye Disease/Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double vision
- ☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Arrhythmia/Irregular Heart Beat
- ☐ Leg Pain when Walking
- ☐ Swelling of Hands/Feet

MUSCULOSKELETAL
- ☐ Muscle Pain or Cramps
- ☐ Joint Pain
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking

GASTROINTESTINAL
- ☐ Indigestion/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

INTEGUMENTARY
- ☐ Rash or Itching
- ☐ Dry Skin
- ☐ Change in Hair/Nails

HEMATOLOGICAL
- ☐ Bruise Easily
- ☐ Slow to Heal

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold
- ☐ Diabetes

NEUROLOGICAL
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Confusion/Memory Loss

STATS

For Office Staff BMI _____

Age _____ Height _____ Weight _____ Shoe Size

BP _____ P _____ O2 Sat _____ Temp _____

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

_____

PATIENT/GUARDIAN SIGNATURE DATE