

Cast A Foot Podiatry, P.C.
Dr Nicole Castillo
474 Fulton Avenue Hempstead NY 11550

Patient Registration Form: *This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be release without your permission.*

Date: _____ Name: _____ Date of Birth: _____

Age: _____ Sex: M F Marital Status: Married Single Minor Widow Divorced

Address: _____ Apartment: _____

Town/City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Primary Doctor: _____ PCP Phone: _____

Referred by: _____

How did you hear about us? _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: _____

Patient's Parent/Guardian Information: ***(if patient is under 18)***

Name: _____ Phone Number: _____

Demographics:

Preferred Language: English
 Spanish
 Other: _____

Pharmacy/Prescription Information:

Walgreens CVS Wal-Mart Target Chubbuck's Xtra Care Bernhard's Freeport Pharm.

Other: _____

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Phone Number: _____

Are you taking any medications/vitamins? Yes No

If yes, please list them below:

Are you allergic to any food? Yes No
Are you allergic to any antibiotics/medicine? Yes No

If yes, please list them below:

No Known Drug Allergies Seasonal Peanuts
 Sulfur Penicillin Iodine
 Food: _____ Antibiotics: _____ Other: _____

History of Present Illness:

Have you ever been to a Podiatrist before: Yes No

If yes, please list: Doctor: _____

Last Visit: _____

Please indicate which foot problems you now have:

<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Cramps/Numbness in feet or legs	<input type="checkbox"/> Ingrown toe nails
<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Flat feet	<input type="checkbox"/> Plantar warts
<input type="checkbox"/> Bunions	<input type="checkbox"/> Fungus	<input type="checkbox"/> Swelling in ankles or Feet
<input type="checkbox"/> Corns & Calluses	<input type="checkbox"/> Heel pain	<input type="checkbox"/> Other: _____

What discomfort do you have with your feet? Left Right

From a scale from 1-10 how would you rate your pain? Please circle one: 1 2 3 4 5 6 7 8 9 10

What makes the pain better or worse? _____

Athletic activities in which you participate (please list and indicate frequency) _____

Medical History: Height: _____ Weight: _____ Shoe Size: _____

	YES	NO		YES	NO		YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Condition	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes If yes, how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other:		

Please list all hospitalizations and surgeries with dates:

Social History:

Do you smoke? Yes No Do you consume alcohol? Yes No Do you use drugs? Yes No

If yes, how much daily/weekly and for how long? _____

Is there a possibility you could be pregnant? Yes No

Family History:

<input type="checkbox"/> Foot problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other:	

I have read the above questions and I have answered them to the best of my knowledge. I authorize Cast A Foot Podiatry Dr Nicole Castillo, staff, and associates to examine and treat me. I also authorize the release of any medical information necessary to process medical insurance claims. In case my health insurance policy does not pay or cover my care expenses, I understand that I am responsible for payment.

Signature: X

Date: