Scott A. Fishman, D.P.M.

193 West Commerce Street - Bridgeton, NJ 08302

Patient Registration Form

Name: _____ please check: Male __ Female __

Birth Date: _____ SS #_____-_____-_____

Address: (mailing/physical) _____

Phone: _____ Cell Phone: _____

Email address: _____ Occupation: _____

Employed By: _____ Employer Address/Phone #: _____

Marital Status: _____ Name of Spouse: _____

Primary Care Physician: _____Address/Phone: _____

IF Patient is a Minor: Name of Parent/ Guardian: _____ D.O.B: _____

Emergency Contact: * Health information is permitted to them: Yes_____ No_____

Name: _____ Relationship: _____

Address: _____ Phone #:_____

Consent: Office can contact you by email address or via phone/text message: Yes_____ No_____

ABN **I request that payment of authorized primary and secondary insurance benefits be made on my behalf directly to Dr. Scott Fishman for any services provided to me. I authorize any holder of medical or personal information about me to be released to the insurance co. and its agents needed to determine these benefits or the benefits payable for related services. I am responsible for any deductible, co-insurance co-pays or non-covered services. Also I have been informed by Scott A. Fishman, D.P.M. that the services performed today may be denied by my insurance/Medicare – Part B as services not covered by insurance /Medicare. I agree to be fully responsible for payment of these services. I, also, understand that all insurances/Medicare Part B, will not reimburse me or the physician for these services.

Patient Signature: _____ Date: _____

Privacy Regulations: A copy is posted in the waiting room and is also available at request.

**I am aware and have access to a copy of the HIPPA privacy regulations and aware my information will not be released to anyone without my authorization.

Do not want a copy _____ was given a copy _____

Patient Signature: _____ Date: _____

DO YOU HAVE A PRESCRIPTION CARD OR PLAN? YES NO

ARE YOU ALLERGIC TO: PENICILLIN YES NO NOVOCAIN YES NO

SHELLFISH YES NO CODEINE YES NO ADHESIVE TAPE YES NO

SULFA YES NO ASPIRIN YES NO

LIST ANY MEDICINES YOU ARE ALLERGIC TO_____

HAVE YOU SEEN A FOOT DOCTOR BEFORE? YES NO

IF YES, WHO, WHEN, AND FOR WHAT PROBLEM?_____

_____

WHAT DO YOU TAKE FOR A HEADACHE?_____

ARE YOU PREGNANT? YES NO

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES NO HIGH BLOOD PRESSURE
YES NO HEART DISEASE
YES NO HEART ATTACK
YES NO HEART VALVE DISEASE
YES NO LUNG DISEASE
YES NO SHORTNESS OF BREATH
YES NO ASTHMA
YES NO ALLERGIES

YES NO STOMACH ULCERS
YES NO DIABETES
YES NO ARTHRITUS
YES NO BLOOD CLOTS
YES NO POOR CIRCULATION
YES NO BLEEDING PROBLEMS
YES NO CANCER
YES NO AIDS / HIV

YES NO THYROID DISEASE
YES NO NERVOUS DISORDERS
YES NO KIDNEY, LIVER DISEASE
YES NO ANEMIA
YES NO SKIN RASHES
YES NO BLOOD TRANSFUSIONS
YES NO SEIZURES / EPILEPSY
YES NO DIFFICULTY HEALING
YES NO SURGERY

ANY FAMILY HISTORY OF: DIABETES HEART DISEASE ARTHRITIS BLOOD CLOTS BLEEDING PROBLEMS

IF YOU HAVE HAD SUGERY PERFORMED, LIST ALL PROCEDURES AND ESTIMATE THE YEAR YOU HAD THE SURGERY.
EXAMPLES: HEART OR LEG BYPASS, HERNIA, HYSTERECTOMY, GALLBLADDER, BACK OR JOINT SURGERY, TONSILS, ETC...

_____

_____

_____

CIRCLE IF YOU HAVE, OR HAVE EVER HAD ANY OF THE FOLLOWING:

CRAMPS WHEN WALKING
LEG OR FOOT CRAMPS AT NIGHT
COLDNESS OF FEET OR LEGS
VARICOSE VEINS
FOOT / ANKLE / LEG SWELLING
EASILY BRUISING SKIN
COLOR CHANGES OF TOES / SKIN
BURNING, TINGLING OR NUMBNESS OF FEET / LEGS
SHOOTING PAIN, UP OR DOWN LEG / FOOT
LEG PAIN
ANKLE PAIN

HEEL PAIN
ARCH PAIN
TOE PAIN
ACHING / TIREDNESS OF FEET / LEGS
ATHLETE'S FOOT / RASHES
PINCHED NERVES, DISC DISEASE
SCIATICA / BACK PAIN
HIP PAIN
KNEE PAIN
GOUT
SORE JOINTS OF FEET

ARTHRITIS
SPURS
BUNIONS
HAMMERTOES
CORNS / CALLOUSES
ULCERS OF LEG / FEET
BROKEN BONES FOOT / ANKLE
INGROWN TOENAILS
FUNGUSED TOENAILS
WARTS

PATIENT SIGNATURE_____

Dr. Scott A. Fishman

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www.scottfishmandpm.com

NAME_____ DATE_____

ADDRESS_____

EMAIL_____ CELL_____

HOME PHONE_____ WORK PHONE_____

HEIGHT_____ WEIGHT_____ BIRTHDATE_____ AGE_____

SOCIAL SECURITY #_____

EMPLOYER_____ OCCUPATION_____

SPOUSE'S EMPLOYER_____ SPOUSE'S SS#_____

HEALTH INSURANCE PLAN_____

GIVE ALL ID #s, MAJOR MEDICAL #s_____

REFERRED BY_____

DID YOU FIND US IN THE YELLOW PAGES, WHITE PAGES, OR ONLINE?_____

WHAT IS YOUR MAIN FOOT PROBLEM?_____

ANY OTHER FOOT PROBLEMS OR QUESTIONS?_____

DO YOU DRINK ALCOHOL? ☐YES ☐NO IF YES HOW MUCH?_____

DO YOU SMOKE? ☐YES ☐NO IF YES HOW MUCH?_____ HOW MANY YEARS?_____

DO YOU TAKE ANTIBIOTICS BEFORE DENTAL WORK? ☐YES ☐NO

YOUR MEDICAL DOCTOR'S NAME_____

WHEN DID YOU SEE YOUR DOCTOR LAST?_____

FOR WHAT DID YOU SEE YOUR DOCTOR?_____

LIST ANY OTHER DOCTORS YOU CURRENTLY SEE_____

LIST ALL MEDICINES, VITAMINS OR OVER-THE-COUNTER MEDICINES YOU NOW TAKE_____

_____

_____

_____

_____

NAME OF PHARMACY YOU CURRENTLY USE_____

(OVER)