K. DAVID FLORA, D.P.M., FACFAS
Foot and Ankle Medicine & Surgery
1086 N. CHERRY STREET
TULARE, CALIFORNIA 93274

PATIENT REGISTRATION FORM

DATE____________________ HOME PHONE#______________________________

CELLULAR/PAGER #______________________________

NAME____ SS#______________________________
FIRST NAME INITIAL LAST NAME

ADDRESS______________________________ CITY______________________________ ZIP____________

BIRTHDATE______________________ CIRCLE ONE : SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED

PATIENT EMPLOYED BY______________________________ OCCUPATION______________________________
(If minor, leave blank)
BUSINESS ADDRESS______________________________ PHONE#______________________________

IS THE PATIENT A FULL TIME STUDENT? YES OR NO ***WHO REFERRED YOU TO DR. FLORA?***______________________________

IN CASE OF EMERGENCY CONTACT:______________________________PHONE#______________________________
(List a relative/friend)

CELL #______________________________

What is the reason for today's visit?______________________________

PRIMARY INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT______________________________
FIRST INITIAL LAST NAME
RELATIONSHIP TO PATIENT______________________ BIRTHDATE____________________ SS#______________________

ADDRESS (IF DIFFERENT FROM PATIENT)______________________________

PLACE OF EMPLOYMENT______________________________ OCCUPATION______________________________

BUSINESS ADDRESS______________________________ PHONE#______________________________

INSURANCE COMPANY______________________________

IS THE PATIENT CURRENTLY COVERED BY ADDITIONAL INSURANCE? _____YES OR _____NO

SECONDARY INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT______________________________
FIRST INITIAL LAST NAME
RELATIONSHIP TO PATIENT______________________ BIRTHDATE____________________ SS#______________________

ADDRESS (IF DIFFERENT FROM PATIENT)______________________________

PLACE OF EMPLOYMENT______________________________ OCCUPATION______________________________

BUSINESS ADDRESS______________________________ PHONE#______________________________

INSURANCE COMPANY______________________________

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I(OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH ______________________________

____
NAME OF INSURANCE COMPANY(IES)

AND ASSIGN DIRECTLY TO DR. K. DAVID FLORA ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELAESE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

______________________________ ______________________ ____________________
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

AGE__________ **SEX**__________ **HT**__________ **WT**__________ **SHOE SIZE**_______

FAMILY PHYSICIAN NAME____ **PHONE #**________________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

_____ ***NO KNOWN DRUG ALLERGIES***

_____ADHESIVE TAPE _____LOCAL ANESTHETICS _____DEMEROL _____SULFA _____ANTICOAGULANT

_____NOVACAINE _____IODINE _____PENICILIIN _____ASPRIN

_____CODEINE _____SEAFOODS _____OTHER____

LIST SURGERIES YOU HAVE HAD: ____

HOSPITALIZATIONS OTHER THAN FOR SURGERIES LISTED: ____

DO YOU SMOKE? YES OR NO

IF YES, NUMBER OF PACKS: ____________ ***HOW MANY YEARS?*** ________________

DO YOU DRINK ALCOHOL? YES OR NO

IF YES: *RARE* *OCCASSIONALLY* *DAILY* ***HOW MUCH?*** ______________

DO YOU HAVE ANY OF THE FOLLOWING:

	YES	OR	NO	*IF YES, PLEASE EXPLAIN*
ABNORMAL BLEEDING ASSOCIATED WITH SURGERY, CUTS, OR TRAUMA (Indicate if taking a **blood thinner**)	_____		_____	______________________
ABNORMAL HEART CONDITION	_____		_____	______________________
HIGH OR LOW BLOOD PRESSURE	_____		_____	______________________
DIABETES	_____		_____	______________________
LEG CRAMPS OR NUMBNESS IN FEET/TOES	_____		_____	______________________
GOUT	_____		_____	______________________
HIGH CHOLESTEROL	_____		_____	______________________
IF FEMALE, ARE YOU PREGNANT? (# of Mo.s)	_____		_____	______________________
LIST ALL OTHER HEALTH PROBLEMS:	_____		_____	______________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? **YES** **OR** **NO**

INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS AND VITAMINS:______________________________________