

Arch Foot Care
Devang C. Patel, P.C.
Podiatrists-Medical and Surgical Foot Care Specialists
761 Main Ave., Norwalk, CT 06851
203-838-0442

PATIENT REGISTRATION FORM

Patient Last Name _____ First Name&Middle initial _____
Street Address _____
City, State, Zip _____

Patient's Phone # _____ Work # _____ Mobile # _____

Patient Marital Status M S D O Employed Y or N Student Full/Part Time

Sex Male Female Patient SSN Patient Date of Birth

Patient's Employer _____ Address _____
Closest Relative _____ Relative Phone# _____

Physician _____ Referred By: _____

RESPONSIBLE PARTY FOR PAYMENT (GUARANTOR)

Guarantor Last Name _____ First Name&Middle initial _____
Address _____ City, State, Zip _____
Employer _____ Address _____
Home Phone _____ Work Phone _____
Sex M F SSN Date of Birth _____
Relationship of Patient to Guarantor Self Spouse Child Other

AUTHORIZATION

Payment is expected at the time of visit. We accept cash, personal checks, and major credit cards for your convenience.

For any services not paid at the time of my visit, I request that payment of benefits be made on my behalf directly to the Provider for any services furnished to me by the provider. I authorize the release of any medical record information necessary to process these claims. This assignment will remain in effect until revoked by me in writing.

All professional services rendered are charged to the patient. Necessary forms will be given to you to expedite insurance carrier reimbursement. The patient is responsible for all fees, regardless of insurance coverage. It is expected that payment for services be made when rendered unless other arrangements have been made in advance.

I hereby give Dr. Devang Patel and/or Dr. Anthony Babigian permission to examine and treat the ailments involving my feet.

Patient/Guardian Signature _____ Date _____

Patient Name _____
Family Physician _____ Physician Address _____

Are you currently under a Doctor's care? If yes, for what? _____

May we contact your physician for your health records if necessary? Yes no

Social History Tobacco _____ Alcohol _____ Recreational drugs _____

Family History heart stroke diabetes gout arthritis cancer

Are you presently pregnant? Yes no Breast feeding yes no

What medications are you taking regularly? _____

Do you have any allergies? _____

What was the reaction? _____

Hospitalizations and Operations _____

Do you have or have you had any of the following? Please circle.

Foot or leg injuries	seizures	fainting spells
Foot or leg numbness	liver disease	bleeding problems
Weak ankles	kidney disease	blood diseases
Bunions	high blood pressure	circulation problems
Skin problems	blood transfusions	hardening of arteries
Toenail problems	stomach ulcers	arthritis
Low back pain	asthma	cancer
Diabetes	anemia	prone to infection
Heart trouble	gout	heart murmur
Hepatitis		
Other _____		

Chief Complaint (what hurts) _____

BELOW TO BE COMPLETED BY OFFICE STAFF AND DOCTOR

Findings _____

	R	L	R	L	R	L
Pulses	DP _____	_____	Edema	_____	Sensory	_____
	PT _____	_____	Temp	_____	CFT	_____

Height _____ Weight _____ BP _____ Shoe size _____

Treatment _____