New Patient Registration Form

Sundance Foot & Ankle

743 N Main St, Spanish Fork, UT 84663
Phone: 385-225-0961
Fax: 385-448-5058

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Address:** _____
- **City:** _____ **State:** _____ **ZIP:** _____
- **Phone Number:** _____
- **Email Address:** _____

Emergency Contact:

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Insurance Information: (for secondary, please provide additional card info to the staff)

- **Primary Insurance Company:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Policy Holder's Name:** _____
- **Policy Holder's Date of Birth:** _____
- **Policy Holder's Phone Number:** _____

Preferred Pharmacy: _____

Medical History:

1. **Reason for Visit:** _____
2. **Current Medications:**
   _____
   _____
   _____
3. **Allergies:** _____
4. **Previous Surgeries (if any, along with any complications):**
   _____
   _____

5. **Have you had any of the following conditions? (Check all that apply):**

☐ Diabetes TYPE I / TYPE II
☐ Arthritis
☐ Previous Foot/Ankle Injuries
☐ Heart Disease
☐ Kidney Disease
☐ Asthma or Respiratory Issues
☐ Cancer (Type: _____)
☐ Fibromyalgia
☐ Neuropathy
☐ Anesthesia Complications
☐ Skin Conditions (e.g., eczema, psoriasis)
☐ Peripheral Neuropathy
☐ Circulatory Problems
☐ High Blood Pressure
☐ Stroke
☐ Liver Disease
☐ Thyroid Disorders
☐ Gout
☐ Multiple Sclerosis
☐ Seizure Disorders
☐ Hypermobility of Joints
☐ Other:

Family History:

- **Do any of the following conditions run in your family? (Check all that apply, and specify which family member: e.g. grandma on mother's side, etc):**
    - ☐ Diabetes _____
    - ☐ Heart Disease _____
    - ☐ Stroke _____
    - ☐ High Blood Pressure _____
    - ☐ Cancer (Type: _____) _____
    - ☐ Kidney Disease _____
    - ☐ Arthritis _____
    - ☐ Neurological Disorders _____
    - ☐ Complications with general or local anesthesia _____
    - ☐ Other:
      _____
      _____
      _____
      _____
      _____

Lifestyle:

- **Do you exercise regularly?** ☐ Yes ☐ No
- **Do you smoke?** ☐ Yes ☐ No If yes, how much? _____
- **Do you drink alcohol?** ☐ Yes ☐ No If yes, how much? _____
- **Do you have any history of recreational or illicit drug use?** ☐ Yes ☐ No

Consent and Acknowledgment:

- I acknowledge that the information provided is accurate to the best of my knowledge. I consent to the examination and treatment by the foot and ankle specialists.

Acknowledgment of Additional Charges:

- I acknowledge that every insurance plan is different and may require me to pay additional charges out of pocket after my visit today. I understand that our billing company may contact me to notify me of additional charges, such as coinsurance, copay, or charges applied to my deductible.

Receipt of Privacy Policies:

- I confirm that I have received a copy of the clinic's privacy policies.

Signature: _____ Date: _____

Office Use Only:

- **Patient ID: _____**
- **Date of Visit: _____**
- **Doctor Assigned: _____**