30 East 40th Street, Suite 401 New York, NY 10016
P: 212. 685.5100 F: 646.742.1577
www.grandcentralpodiatry.com

PATIENT REGISTRATION FORM

Patient Information:
Last Name: _____ First Name: _____ Middle: ____
Sex: ☐ M ☐ F Date of Birth: _____ SSN:_____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
Employer: _____ Address: _____
Primary Physician: _____ Phone Number: _____

Emergency Contact:
First Name: _____ Last Name: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Relationship: _____

Health Coverage:
Primary Insurance: _____ Member ID#: _____
Secondary Insurance: _____ Member ID#: _____
Subscriber's Name (if not self): _____ DOB: _____
Subscriber's SSN: _____ Relationship:
_____

How did you hear about the practice? (circle one)

Internet/Google Friend/Family* Doctor Referral*

Insurance Company* Facebook

(*who?) _____
Other _____

SHOE SIZE: _____

PATIENT HEALTH HISTORY

Please describe your problem: _____
_____

Do you have pain? ☐Y ☐N When did it start? _____
If so, where is it located? _____
Describe its quality? (stabbing, shooting, burning) _____
How severe is it? (mild, moderate, severe): _____
How long does it last? _____
Do shoes make it better or worse? _____
What medications are you taking? _____
What surgeries have you had in the last 5 years? _____

Is there a family history of diabetes? ☐Y ☐N
Is there a family history of heart disease? ☐Y ☐N
Is there a family history of lung cancer? ☐Y ☐N
Do you smoke? ☐Y ☐N Do you drink alcohol? ☐Y ☐N
Do you wear glasses or contacts? ☐Y ☐N
Any fever or unexplained weight loss the last year? ☐Y ☐N
Any numbness or tingling in your toes or feet? ☐Y ☐N
Any history of stomach ulcers or problems? ☐Y ☐N
Any history of arthritis or joint pain? ☐Y ☐N
Are you pregnant? ☐Y ☐N If yes, how far along? _____

Are you allergic to any of the following?:
Adhesive Tape ☐ Penicillin ☐ Local Anesthetic (Novocain) ☐
Please list any other allergies that you have: _____

Do you have any of the following?:

____ Heart Disease	____ AIDS or HIV	____ Circulatory Disease
____ Diabetes	____ Kidney Trouble	____ High Blood Pressure
____ Gout	____ Hepatitis	____ Mental Health Problems
____ Liver Trouble		