Ribeiro Foot & Ankle Center

Carla Ribeiro-Bachtell, DPM, FACFAS
4660 Kenmore Avenue, Suite 602
Alexandria, VA 22304

Ph: (703) 637-9917
Fax: (703) 566-5201
www.ribeirofootandankle.com

REGISTRATION FORM (Please Print)

PATIENT INFORMATION

Date _____Home Phone( )_____Cell Phone( )_____ Email _____

Last Name_____ First Name_____ Middle Initial____ Date of Birth ___/____/____

Street_____City_____State_____Zip_____

Social Security #_____-_____-_____Age____ Sex ❑M ❑F Marital Status_____ Primary language: _____

Ethnicity: (Circle one) _ American Indian _Asian _ Black African American _ Native Hawaiian/Pacific Islander _White _ Hispanic

Occupation_____ Work phone( )_____

Employer_____

Pharmacy:_____ Address:_____ City & Zip_____ Phone # _____

In case of Emergency contact_____ Relationship_____ Phone ( )_____

FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Relationship to patient_____ Home Phone ( )_____Cell Phone ( )_____

Last Name_____ First Name_____ Middle Initial_____ Sex ❑ M ❑ F

Street_____City_____State_____Zip_____

Social Security #_____Age_____ Date of Birth____/____/_____Marital Status_____

INSURANCE INFORMATION (COPY OF CARD(S) REQUIRED)

Primary Insurance_____ Insured's Name_____

Secondary Insurance_____ Insured's Name_____

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Phone Book ☐ Friend ☐ Google ☐ Women's Journal

☐ Family/Friend ☐ Insurance Plan ☐ Hospital/ER ☐ Gazette ☐ YELP ☐ Other_____

FAMILY PHYSICIAN INFORMATION

Did your Family Physician or other specialist refer you? ❑ Yes ❑ No Did you independently come for an opinion? ❑ Yes ❑ No

Referring/Family Physician:_____ **Date last seen:**_____

Address: _____**City**_____**State**_____**Zip**_____

Phone: ( )_____

MEDICAL HISTORY

PATIENT NAME **BIRTH DATE** / /

What is your foot/ankle problem? _____

_____

Location? Right or Left

When did the problem begin? Date: _____

Describe any accident/event: _____

Is the problem work related? Yes/ No

First visit to a doctor for this problem? **Yes** / **No**, who?

_____

Describe any previous treatment or home remedies?

_____

_____

List any sports/activities:

_____

On a scale of 0-10 with 10 being worst please rate your pain today:

0 1 2 3 4 5 6 7 8 9 10

ALLERGIES

- ❑ Penicillin
- ❑ Sulfa
- ❑ Local Anesthetic
- ❑ Anti-inflammatory Medication
- ❑ Codeine
- ❑ Adhesive Tape
- ❑ Latex
- ❑ Iodine on Skin
- ❑ IV Radio contrast Dye
- ❑ Cortisone
- ❑ Other_____
- ❑ None_____

REVIEW OF SYSTEMS (CIRCLE Y OR N

Headaches	**Y / N**	Excessive Thirst	**Y / N**
Nausea	**Y / N**	Chest Pain	**Y / N**
Bloody Stool	**Y / N**	Shortness of breath	**Y / N**
Abdominal Pain	**Y / N**	Depression	**Y / N**
Pain on urination	**Y / N**	Nosebleed	**Y / N**
Skin Rashes	**Y / N**	Calf Pain	**Y / N**
Fever	**Y / N**	Healing difficulty	**Y / N**
Bone /Joint Pain	**Y / N**	Dizziness	**Y / N**
Blurred Vision	**Y / N**	Inc weight loss	**Y / N**

LIST OF CURRENT MEDICATIONS

❑ **NONE**

WHAT PREVIOUS SURGERIES HAVE YOU HAD? CHECK ALL THAT APPLY AND LIST ANY OTHERS

- ❑ Hysterectomy
- ❑ Cardiac(valve, pacemaker, graft, etc)
- ❑ Implant surgery (knee, hip, etc)
- ❑ Gallbladder removed
- ❑ Vascular Leg Bypass
- ❑ Appendectomy
- ❑ Tonsillectomy
- ❑ Hernia repair
- ❑ Cosmetic
- ❑ Cancer Surgery
- ❑ Other surgeries including any FOOT/ANKLE surgery:

Have You Ever Been Put To Sleep For Surgery? **Yes** ☐ **No** ☐ **Complications with Anesthesia?** **Yes** ☐ **No** ☐

Height:_____

Weight:_____

Shoe size:_____

Do you drink alcoholic beverages?
- ❑ No
- ❑ Yes, socially
- ❑ Daily

Drinks/week_____

Do you smoke cigarettes?
- ❑ No, never
- ❑ No, I quit
- ❑ Yes currently

Packs/Day_____ #Years_____

Do you use "recreational" drugs?
- ❑ No, never
- ❑ No, I quit
- ❑ Yes

WHICH ONES?

	SELF		BLOOD RELATIVE		SELF		BLOOD RELATIVE
Anemia	❑ Yes	❑ No	❑ Family	High Blood Pressure	❑ Yes	❑ No	❑ Family
Arthritis/Rheumatism	❑ Yes	❑ No	❑ Family	High Cholesterol	❑ Yes	❑ No	❑ Family
Asthma or Respiratory Problems	❑ Yes	❑ No	❑ Family	H.I.V. Positive	❑ Yes	❑ No	❑ Family
Birth abnormalities	❑ Yes	❑ No	❑ Family	Infections (MRSA, VRE)	❑ Yes	❑ No	❑ Family
Blood Clots or Bleeding Disorders	❑ Yes	❑ No	❑ Family	Kidney Trouble	❑ Yes	❑ No	❑ Family
Cancer or tumor	❑ Yes	❑ No	❑ Family	Liver Disease	❑ Yes	❑ No	❑ Family
Diabetes Insulin Dependent	❑ Yes	❑ No	❑ Family	Neurological Disorder	❑ Yes	❑ No	❑ Family
Diabetes Non-Insulin Dependent	❑ Yes	❑ No	❑ Family	Psychiatric / Psychological Care	❑ Yes	❑ No	❑ Family
Fibromyalgia / Reflex Sympath Dyst	❑ Yes	❑ No	❑ Family	Stroke/CVA/TIA	❑ Yes	❑ No	❑ Family
Glaucoma	❑ Yes	❑ No	❑ Family	Sickle Cell Disease/Trait	❑ Yes	❑ No	❑ Family
Heart (Surgery, Disease, Attack)	❑ Yes	❑ No	❑ Family	Stomach Ulcers / Reflux	❑ Yes	❑ No	❑ Family
Hepatitis A (Infectious B/C)	❑ Yes	❑ No	❑ Family	Ulcers (Diabetic)	❑ Yes	❑ No	❑ Family

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any changes in my health or medication.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

X

Patient/Guardian Signature Date

MEDICAL HISTORY REVIEWED BY (DR. SIGNATURE): DATE