

FOOT AND ANKLE CENTER OF THE CENTRAL COAST  
PETER C. FILLERUP D.P.M.

PATIENT REGISTRATION

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's SS# \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Sex: M F Shoc Size: \_\_\_\_\_  
Last First M. Initial

**I, request that all communications to me (via: phone, mail or otherwise) by The Foot and Ankle Center of the Central Coast: Dr' Fillerup's Office and/or its staff, be handled in the following manner:**

Address for written communications: \_\_\_\_\_  
City State Zip code

Billing address if different from above: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City State Zip code Ext: Cell Phone:

Where do you prefer to receive calls? \_\_\_\_\_ **May we leave a message?** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Pharmacy used: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Signature of Patient or authorized representative: \_\_\_\_\_

PATIENT MEDICAL HISTORY

*Have you ever had/have the following conditions:  
Circle those that apply:*

|                  |                 |                         |                      |
|------------------|-----------------|-------------------------|----------------------|
| Diabetes         | Arthritis       | Excessive Bleeding      | Asthma               |
| Tuberculosis     | Fractures       | Blood Clots             | Bronchitis           |
| Cancer           | Polio           | Arteriosclerosis        | Emphysema            |
| Heart Disease    | Stroke          | High/Low Blood Pressure | Ulcers               |
| Kidney Disease   | Gout            | Anemia                  | Pregnant (currently) |
| Back Problems    | Hepatitis A B C | Rheumatic Fever         | HIV/AIDS             |
| Thyroid Disorder | Ankle Swelling  | Epilepsy                | Other: _____         |

Have any member of your family or close relative ever had? : Heart Disease Diabetes Asthma Cancer Stroke

Do you have allergies to any medications? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ Yrs.? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Last visit at Primary Care Provider \_\_\_\_\_

PODIATRIC HISTORY

Please indicate which foot problems you've had or are now experiencing: (please circle)

|            |                  |                  |             |             |           |                     |
|------------|------------------|------------------|-------------|-------------|-----------|---------------------|
| Ankle Pain | Athlete's Foot   | Corns/Calluses   | Nail Fungus | Flat Feet   | Heel Pain | Warts on foot/ankle |
| Tired Feet | Numbness in feet | Swelling in feet | Bunion Pain | Other _____ |           |                     |

**INSURANCE INFORMATION**

Primary Insurance

Secondary Insurance

Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
Copay \_\_\_\_\_ Deductible \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
Copay \_\_\_\_\_ Deductible \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_

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**AGREEMENT AND RELEASE**

*I, the undersigned, certify that I or my dependent have insurance coverage with (name of insurance company) \_\_\_\_\_ and assign directly to Dr. Peter C. Fillerup all insurance benefits, if any, otherwise payable to me for services rendered.*

*I also authorize the release of any information including the diagnosis and / or treatment rendered to myself or dependent during the period of such care to third party payors and / or other health care practitioners.*

*I understand that my insurance carrier may pay less than the actual charges for any and all services. I also agree to be financially responsible for payment for all services rendered and supplies provided for myself or dependents.*

\_\_\_\_\_  
*Responsible Party Signature*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Date*

*I hereby give permission to Dr. Peter C. Fillerup to administer treatment as agreed to be deemed necessary in the diagnosis and / or treatment of my Podiatric condition.*

\_\_\_\_\_  
*Responsible Party Signature*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Date*

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**I acknowledge that I was offered a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so choose) and understand the notice:**

**Signature of Patient or authorized representative \_\_\_\_\_ Date \_\_\_\_\_**