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# BRIAN K. DOERR, DPM, PA

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*Diplomate, American Board of Podiatric Surgery • Certified in Foot and Ankle Surgery*

PATIENT REGISTRATION

TODAYS DATE \_\_\_\_\_

**PLEASE FILL OUT COMPLETELY**

Patients full name:

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sex M F

Patient SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status S M D W Name of Spouse \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Local Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Local Pharmacy \_\_\_\_\_ Pharmacy # \_\_\_\_\_

Second or out of state address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_

Dates at out of state address \_\_\_\_\_ to \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_

Occupation \_\_\_\_\_

**Whom should we contact in case of emergency** \_\_\_\_\_

**Relationship to Emergency Contact** \_\_\_\_\_

**Phone number of Emergency Contact** \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ If referred, by whom? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Date last seen: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

Who is your Primary Insurance Carrier \_\_\_\_\_

Who is your Secondary Insurance Carrier \_\_\_\_\_

Are you the primary card holder? YES or NO

IF NO please provide name primary card holder \_\_\_\_\_

Date of Birth of primary card holder \_\_\_\_\_

SS # of primary card holder or parent/guardian \_\_\_\_\_

**CONSENT FOR EXAMINATION AND TREATMENT  
LIFETIME SIGNATURE AUTHORIZATION, FINANCIAL RESPONSIBILITY**

**Consent for Examination and Treatment:**

I hereby request and give permission to Dr. Brian K. Doerr and whomever he may designate as his assistants to administer treatment, and to perform such general procedures as he may deem to be necessary in the diagnosis and/or treatment of my foot complaints.

**Lifetime Signature Authorization:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or other insurance carriers or to the billing agent of Brian K. Doerr, DPM any information needed for this and or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Brian K. Doerr, DPM or the party who accepts assignment.

**Financial Responsibility:**

I agree to be financially responsible for any deductibles, co-insurance and/or co-payments at time of service unless prior arrangements have been made. I also guarantee the payment for any denied or uncovered claims which may be due to Dr. Doerr for professional services rendered to me on my behalf. I agree that I will be responsible for the legal fees and collection costs associated with my failure to pay amounts due and owing Dr. Doerr. Any checks returned for non-sufficient funds will result in an additional \$25 charge per item added to the account balance, which I agree to pay in full.

**Referrals and Authorizations:**

If your insurance has designated a primary care physician (PCP), you may be required to have prior authorization from your PCP prior to your office visit with Dr. Brian K. Doerr. If authorization is required and not provided, you will be asked to either reschedule your appointment or pay for the visit in full at the time of service.

Name of patient (Print) \_\_\_\_\_

Patient's or Guardian's Signature \_\_\_\_\_

Relationship to patient (Print) \_\_\_\_\_

Date \_\_\_\_\_



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## BRIAN K. DOERR, DPM, PA

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*Diplomate, American Board of Podiatric Surgery • Certified in Foot and Ankle Surgery*

**PATIENT NAME** \_\_\_\_\_

**TODAYS DATE** \_\_\_\_\_ **PATIENT REGISTRATION** \_\_\_\_\_

Please describe your medical problem / what brings you to the office today?

\_\_\_\_\_

\_\_\_\_\_

How would you describe your pain?

sharp      aching      throbbing      burning      cramping  
shooting      electrical sensation      pins and needles      numbness

Location of pain or primary complaint:

lower leg    ankle    achilles tendon    heel    midfoot    arch    forefoot  
sole of foot    ball of foot    top of foot    big toe    lesser toes    toenails  
Other \_\_\_\_\_

How long has your problem been present?

1 – 3 days      3 – 7 days      1 – 3 weeks      3 – 6 weeks      6 – 8 weeks  
3 – 6 months      6 – 9 months      9 – 12 months      greater than 1 year

Onset of condition or injury:

gradual onset over time      sudden onset from activity or injury

Course/progression of condition:

severe worsening    moderate worsening    mild worsening    steady/unchanging  
mild improvement    moderate improvement    considerable/good improvement

Have you attempted any treatments to relieve your problem?

rest    ice    elevation    change shoe gear    over the counter padding  
in home whirlpool    stretching    trimming out toenail yourself    applying skin cream  
over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)  
applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin)  
saw another physician for this problem - instructed to be seen in this office  
treated for this condition by another physician  
surgery for this condition by another physician

Pain/condition aggravated by:

any weight bearing standing walking running exercise bending stooping  
pressure on ball of foot pressure from shoes pressure from jumping  
rubbing from clothing

Additional factors that aggravate the pain:

pain worse first thing in the morning when walking/activity pain worse in shoes  
pain worse when standing and walking after rest pain worse with any movement  
pain worse after running/ exercise pain worse after working on ladder  
pain decreases after 1st 15- 20 minutes of walking pain decreases after rest  
pain decreases after removing shoes pain decreases after rubbing area  
pain decreases after trimming out toenail, but returns in several days

How much improvement and relief have you achieved with previous treatments?

mild improvement moderate improvement considerable improvement  
no improvement worsening of condition

What is your activity level at work :

sitting standing walking considerable movement/walking retired

How did you hear about our office?

Physician family/friend internet newspaper phone book advertisement

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI  
insulin dependent diabetes non insulin dependent diabetes pre diabetic  
blood clot stroke/CVA aneurysm

Do you have:

fatigue nausea chills  
weight gain greater than 10 pounds weight loss greater than 10 pounds

**Eyes** - Do you have:

impaired vision cataracts glaucoma  
macular degeneration frequent eye infections

**Ears** - Do you have:

hearing loss frequent ear infections  
dizziness loss of balance

**Nose** - Do you have:

sinus problems/allergies frequent nose bleeds difficulty breathing  
nasal polyps deviated septum

**Medications for the above condition** \_\_\_\_\_



**Endocrine** - Do you have:

Diabetes                      Thyroid disease

**Medications for the above condition** \_\_\_\_\_

**Neurological** - Do you have:

seizures   stroke   tremor   change in memory   frequent head aches   polio  
muscle weakness   neuro-muscular disease   numbness   sciatica

**Medications for the above condition** \_\_\_\_\_

**Musculoskeletal** - Do you have:

arthritis/degenerative joint disease   rheumatoid arthritis   gout   back pain  
hip pain   knee pain   frequent muscle/tendon/pain   fibromyalgia

**Medications for the above condition** \_\_\_\_\_

**Musculoskeletal** - Do you have any of the following joint replacements/prosthesis:

hip                      knee                      ankle  
hands                      feet                      spine

Date of joint replacement: \_\_\_\_\_

**Integument** - Do you have:

skin rashes   psoriasis   eczema   skin cancer   hives   skin growth  
color change to mole or wart   change in size of skin growth   itching to skin  
thick scar/keloid

**Medications for the above condition** \_\_\_\_\_

**Psychiatric** - Do you have:

depression   nervousness   anxious/OCD   phobias   bipolar disease   memory loss  
concentration difficulties/ADHD   feelings of worthlessness/low self esteem  
suicidal   schizophrenia/psychosis

**Medications for the above condition** \_\_\_\_\_

**Immunology** - Do you have:

HIV   Frequent infections/weak immune system   chronic fatigue syndrome/Ebstein Barr

**Medications for the above condition** \_\_\_\_\_

**Past Foot Surgeries:** Have you had any of the following surgeries?

toenail   bunion   hammertoe   fracture repair   joint fusions  
tendon repair/rerouting   ankle stabilization   arthroscopy   fasciotomy

Please list approximate month **AND** year of any surgery listed above:

\_\_\_\_\_

**Past Surgical History:** Have you had any of the following surgeries?

heart bypass      heart valve repair/replacement      appendectomy  
gallbladder      brain surgery      other

Please list approximate month **AND** year of any surgery listed above:

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Any other surgeries/injuries/traumas? (Please specify type of surgery and date)

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Any complications/problems with surgery or anesthetics? (please specify)

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**Previous hospitalization** - have you been admitted for:

heart attack      stroke      pneumonia      cancer  
infection      injury      other hospitalizations

Please list approximate month and year of any hospitalization listed above:

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**Childhood History** – Have you ever had:

rheumatic fever      measles      mumps      chickenpox      herpes/cold sores

**Childhood Immunizations** – have you been immunized for:

measles      mumps      rubella      diphtheria      tetanus      varicella      zoster  
polio      tuberculosis      pneumonia      pertussis      flu

**Family History - Father** - Does/Did your father have:

hypertension/high blood pressure      CVA/stroke      diabetes  
cancer      circulation problems  
Any other illnesses? (please list)

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Is your father deceased?                      yes                      no

If your father is deceased - age and cause of death \_\_\_\_\_

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**Family History - Mother** - Does/did your Mother have:

hypertension/high blood pressure      CVA/stroke      diabetes  
cancer      circulation problems  
Any other illnesses? (please list)

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Is your mother deceased?                      yes                      no

If your mother is deceased - age and cause of death \_\_\_\_\_

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**Family History Siblings** - Does/Did your siblings have:  
hypertension/high blood pressure      CVA/stroke      diabetes  
cancer      circulation problems  
Any other illnesses? (please list)

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**Social History** - Do you:  
smoke tobacco      smoke marijuana      use hallucinogenic drugs  
drink alcohol      use cocaine      use other recreational drugs  
**If you use other recreational drugs - please list/specify:**

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Number of drinks per day?  
1      2      3      4      5      greater than 5 per day      1-3/week      4-6/week  
Occasional use only      social drinking only      weekend drinking only

**Smoking Status**  
Never smoked      Current everyday smoker      Social smoker      Unknown if ever smoked

**If you smoke, number of packs per day?**  
1/2      1      2      3      4      5 or more  
1-2/week      3-4/week      Occasional      social      weekends

**Former smoker**  
Please specify how long since you stopped smoking **AND** how many years you smoked

Stopped smoking less than 6 months ago	Smoked for less than 5 years
Stopped smoking 6 to 12 months ago	Smoked for 5 to 10 years
Stopped smoking 1 to 2 years ago	Smoked for 10 to 15 years
Stopped smoking 2 to 5 years ago	Smoked for 15 to 20 years
Stopped smoking greater than 5 years ago	Smoked for greater than 20 years

**Women** - Are you pregnant?  
yes      no  
If pregnant, number of months: \_\_\_\_\_

**Education:**  
did not complete high school      completed high school      some college  
completed college      some grad school      masters degree      doctorate degree

**Medications** - please list any medications not listed above (including aspirin) currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** - Do you have allergies to any of the following:

drug allergies	penicillin	sulfa	erythromycin
aspirin	cortisone	codeine	adhesive tape
local anesthetics	iodine	latex	<i>no known allergies</i>

Please list severity **AND** type of allergic response:

mild moderate severe skin rash itching hives GI upset nausea/vomiting  
diarrhea wheezing respiratory distress rapid pulse heart palpitations anaphylaxis

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Do you have any allergies to **plants** – is so, please list:

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Do you have any **food** allergies - if so, please list:

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What is your height?

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What is your weight?

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Shoe size?

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