Active Feet Clinic
Dr. Philip K. Schrumpf, DPM
2835 Fort Missoula Road
PC3, Suite 304
Missoula, MT 59804
(406) 542-0800

REGISTRATION FORM

(Please give insurance card(s) and photo ID to our front office)

Name (Last)_____(First)_____(MI)_____Nickname)_____

Physicial Address_____City_____State_____Zip_____

Mailing Address_____City_____State_____Zip_____

Home Phone_____Cell_____Work_____

IN CASE OF EMERGENCY, CONTACT

Name_____Phone_____

E-Mail_____ Sex M or F Age_____ Date of Birth_____ SS#_____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ___ years

Patient Employer/School_____

Spouse's Name_____ Birthdate_____Phone_____

How did you hear about the practice? ☐ *Internet/Google* ☐ *Friend/Family* ☐ *Facebook* ☐ *Insurance Company*

*Physician Referral (Name)*_____ *Other*_____

INSURANCE

Who is Responsible For This Account?_____ Relationship to Patient_____ Date of Birth_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints)_____
_____

Have you ever been to a Podiatrist before ☐ Yes ☐ No If yes, please list. Name _____ Last visit_____

Your occupation_____

Cigarette/Tobacco use ☐ Yes ☐ No If yes, years smoked_____

Athletic activities in which you participate (please list and indicate frequency)_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No	Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Athlete's Feet	☐ Yes	☐ No	Heel Pain	☐ Yes	☐ No
Bunions	☐ Yes	☐ No	Ingrown Toenails	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No	Plantar Warts	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No	Swelling in Ankles or Feet	☐ Yes	☐ No

☐ Other_____

MEDICAL HISTORY

Place a mark on "Yes or No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐ No	Epilepsy	☐Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergies to Anesthetics	☐Yes	☐ No	Eye Problems	☐Yes	☐ No	Shortness of Breath	☐Yes	☐ No
Allergies to Medications	☐Yes	☐ No	Fainting	☐Yes	☐ No	Sinus Problems	☐Yes	☐ No
Anemia	☐Yes	☐ No	Gout	☐Yes	☐ No	Special Diet	☐Yes	☐ No
Angina	☐Yes	☐ No	Headaches	☐Yes	☐ No	Stroke	☐Yes	☐ No
Arthritis	☐Yes	☐ No	Heart Disease	☐Yes	☐ No	Swollen Neck Glands	☐Yes	☐ No
Artificial Heart Valves	☐Yes	☐ No	Hemophilia	☐Yes	☐ No	Tuberculosis	☐Yes	☐ No
Artificial Joints	☐Yes	☐ No	Hepatitis or Jaundice	☐Yes	☐ No	Ulcers	☐Yes	☐ No
Asthma	☐Yes	☐ No	High Blood Pressure	☐Yes	☐ No	Varicose Veins	☐Yes	☐ No
Back Problems	☐Yes	☐ No	Kidney Problems	☐Yes	☐ No	Venereal Disese	☐Yes	☐ No
Bleeding Disorders	☐Yes	☐ No	Liver Disease	☐Yes	☐ No	Weight Loss, Unexplained	☐Yes	☐ No
Cancer	☐Yes	☐ No	Low Blood Pressure	☐Yes	☐ No			
Chemical Dependency	☐Yes	☐ No	Neuropathy	☐Yes	☐ No			
Chest Pain	☐Yes	☐ No	Phlebitis	☐Yes	☐ No			
Chronic Diarrhea	☐Yes	☐ No	Psychiatric Care	☐Yes	☐ No			
Circulatory Problems	☐Yes	☐ No	Radiation Treatment	☐Yes	☐ No			
Diabetes	☐Yes	☐ No	Rash	☐Yes	☐ No			
Ear Problems	☐Yes	☐ No	Respiratory Disease	☐Yes	☐ No			

Surgeries you have had _____
_____
_____

Hospitalization other than for surgeries listed_____
_____

Primary Care Physician_____ Last visit date_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐ No

If yes, please explain_____
_____

MEDICATIONS

(*Include prescriptions, over -the-counter medications and vitamins*)
(Please include the dosage and frequency)

_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name(s)_____

ALLERGIES

□ Adhesive /Tape
□ Anticoagulant Therapy
□ Aspirin
□ Codeine
□ Demerol
□ Antibiotics_____
□ Other_____
□ Local Anesthetics
□ Novocaine
□ Seafoods
□ Sulfa
□ Iodine

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____