DR. MICHAEL CONNOR
Doctor of Podiatric Medicine & Surgery
27 Danbury Road
Wilton, CT 06897
(203) 761-1230

PATIENT REGISTRATION FORM

DATE:_____

NAME:_____AGE____SEX____WEIGHT_____
HT._____ B.P._____

ADDRESS:_____CITY_____ZIP CODE_____

TEL:_____DATE OF BIRTH:_____S.S. #_____

OCCUPATION:_____EMPLOYED BY:_____

BUSINESS TEL.:_____MARITAL STATUS: M S W D (circle one)

SPOUSE'S NAME:_____DATE OF BIRTH:_____

SPOUSE'S S.S.#_____SPOUSE'S EMPLOYER:_____

PHYSICIAN:_____LAST VISIT:_____

PREVIOUS PODIATRIST:_____LAST VISIT_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

NAME & ADDRESS:_____

DO YOU HAVE HEALTH/MEDICAL INSURANCE?_____NO_____YES

NAME/ADDRESS OF COMPANY:_____

IDENTIFICATION NUMBER:_____GROUP #_____

NAME OF INSURED:_____

OTHER HEALTH/MEDICAL INSURANCE_____

_____Please check here and initial for permission to forward your progress notes to your doctor.

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH & PHYSICAL CONDITION?

GOOD_____FAIR_____POOR_____(check one)

DO YOU HAVE OR DID YOU EVER HAVE: (please circle)

DIABETES.....	YES NO	MIGRAINE HEADACHES.....	YES NO
CANCER.....	YES NO	GALL BLADDER DISEASE	YES NO
LIVER DISEASE.....	YES NO	EASY BRUISING.....	YES..NO
ARTHRITIS.....	YES NO	HIGH BLOOD PRESSURE...	YES NO
MUSCLE SPASMS....	YES NO	COLD HANDS&FEET.....	YES.. NO
ANEMIA.....	YES NO	TINGLING/BURNING FEET..	YES..NO

HAVE YOU EVER HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS SURGERY OR TRAUMA?.....YES NO

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?.....YES NO

LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:_____

_____

_____

LIST ALL SENSITIVITES TO MEDICATIONS:_____

LIST PREVIOUS HOSPITALIZATIONS&SURGERIES W/APPROX. DATE:_____

_____

DO YOU SMOKE? YES_____NO_____ FORMER SMOKER_____

DO YOU DRINK? YES_____NO_____ IF SO,HOW MUCH?_____

The undersigned patient hereby authorizes this practice to submit Insurance Carrier Claim Forms on behalf of the patient without further signature authorization. This form also authorizes this practice to receive payments directly from the Insurance Carrier. ALL claim forms will be submitted to the Carrier with the notation "SIGNATURE ON FILE."

DATE:_____SIGNATURE:_____

For updates on office hours, special events, emergencies, appointment confirmation and newsletters, please provide your e-mail address. Please print clearly. Thank you.

E-MAIL_____

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notices of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Patient Signature

_____

Patient or authorized representative