PH:305-835-8000 FAX:305-835-0866

E-FAX:305-249-1825

REGISTRATION FORM

PATIENT INFORMATION:

Date of Service:_____

LAST NAME:_____FIRST NAME:_____ MI:_____

SUFFIX:_____ OTHER NAME:_____(S)

PRIMARY CARE DOCTOR:_____

REFERRING DOCTOR:_____

DATE LAST SEEN BY PRIMARY CARE DOCTOR:_____

SS#_____ DOB:___/____/____ EMAIL:_____

ADDRESS:_____ CITY/STATE:_____

ZIP:_____ HOME PHONE:_____ WORK PHONE:_____

CELL:_____

IN CASE OF EMERGENCY

CONTACT NAME:_____ RELATIONSHIP:_____

WORK/CELL/HOME#_____

The above information is true to the best of my knowledge.

Signature:_____ Date:_____

PHARMACY INFORMATION

NAME:_____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ TEL:_____

****Please bring a list of your prescribed medication ready to give the Medical Assistant. If you did not bring it with you today, Please make sure you bring a copy to your follow-up visit. Thank You****

MARIAN DAVIS DPM PA

1190 NW 95TH ST Suite 401

MIAMI, FLORIDA 33150

PH:305-835-8000 FAX:305-835-0866

E-FAX:305-249-1825

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

INSURANCE NAME:_____

INSURANCE PLAN:_____

TYPE:_____

PATIENT'S RELATIONSHIP TO SUBSCRIBER:_____

POLICY#:_____ GROUP #_____

SUBSCRIBER EMPLOYER:_____

SUBSCRIBER NAME:_____

SECONDARY INSURANCE INFORMATION:

INSURANCE NAME:_____

INSURANCE PLAN:_____

TYPE:_____

PATIENT'S RELATIONSHIP TO SUBSCRIBER:_____

POLICY#:_____ GROUP #_____

SUBSCRIBER EMPLOYER:_____

SUBSCRIBER NAME:_____

Marian Footcare

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DO I NEED A PAD TEST?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain or kidneys becomes narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

NAME:_____ DATE:_____

Circle “Yes” or “No”:

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when walking? YES NO
2. Do you experience any pain at rest in your lower leg (s) or feet? YES NO
3. Do you experience foot or toe pain that often disturbs your sleep? YES NO
4. Are your toes or feet pale, discolored or bluish? YES NO
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal? YES NO
6. Has your doctor ever told you that you have diminished or absent pedal (foot) muscles? YES NO
7. Have you suffered a severe injury to the leg(s) or feet? YES NO
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? YES NO