ANTHONY SIKOUTRIS, D.P.M.

Central Missouri Podiatry, Inc.
519 E 13th St, Sedalia, MO 65301
(660) 827-6311 Fax: (660) 827-5183

PATIENT REGISTRATION
(Please print clearly or circle)

Patient's Full Name as on Insurance card: ______________________ **Age:** _____ **Date of Birth:** __________
Sex: Male Female **Marital Status:** Single Married Divorced Widowed **Ethnicity:** Non-Hispanic Hispanic
Race: White African American Asian Pacific Islander American Indian Unknown Decline to Say
Preferred Language: Eng Spa Other________

Mailing Address: ____
Street City State Zip
Social Security Number: ______________________ **Cell Phone:** ______________________
EMAIL: ______________________ **Home Phone:** ______________________
Place of Employment: ______________________ **Work Phone:** ______________________
Patient's Family Doctor: ______________________ **Date of Last Visit:** ______________________
Who referred you to, or how did you hear of, Dr. Sikoutris? ______________________
☐ Doctor ☐ Phonebook ☐ Internet ☐ Friend ☐ Family

Spouse or Guardian: ______________________ **Employed by:** ______________________
Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________
Social Security Number: ______________________ **Date of Birth:** ______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed by Central Missouri Podiatry, Inc. that the "Notice of Information Practices" is available in their waiting room for review. I understand that I have the right to ask questions in order to seek clarification and/or request a copy of this document.
Any medical, scheduling, or billing information may be discussed with the following:

____
Authorized person to speak with and Phone number

X ______________________________
Signature of the Patient or Guardian

AUTHORIZATION OF OFFICE AND PAYMENT POLICY

X______________________ I have read and understand the office policies regarding updating my information, payment contracts, insurance filing, co-pays, and collections. I have also been given a copy of the policies.

INSURANCE INFORMATION

Primary Insurance: ______________________ I.D. or Policy #: ______________________
Policy holder Name: ______________________ Date of birth: ______________ Copay:________
Secondary Insurance: ______________________ I.D. or Policy #: ______________________
Policy holder Name: ______________________ Date of birth: ______________ Copay:________

PLEASE NOTE: PATIENT OR GUARDIAN IS RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

AUTHORIZATION

I hereby authorize Anthony Sikoutris, D.P.M. to furnish the necessary information to my insurance carrier(s) and referring physician concerning my diagnosis and treatment. I certify that the above information is true, accurate, and complete. I also authorize, where applicable, that my insurance benefits be paid directly to Anthony Sikoutris, D.P.M. in care of Central Missouri Podiatry, Inc. I understand that I am financially responsible for all charges accrued.

X ____
Signature of Patient or Guardian Date of Signature

Name: ____________________ Weight: ______________ Height: ________________

Social and Preventive History

Do you currently smoke or chew tobacco? □Yes □No If no, have you in the past? □Yes □No

Family History

List any serious illness

Mother ________________

Father ________________

Additional Patient History

Did you have FLU shot? YES NO If no, Declined, Allergic, or Unavailable

Do you have a Living Will? YES NO

Have you had a Pneumonia Vaccination? YES NO

Please list all **drug allergies** and the reaction you had: ____

____

Please list **all current medications** with dosage and how often you are taking them. Please include all non-prescription drugs. ____

____

____

____

***What is your preferred pharmacy AND city it is in? ____

Do you have a history of:

☐ Diabetes A1c_______ Date last Vist __________	☐ Lung Problems
☐ Peripheral Vascular Disease (PVD)	☐ Asthma
☐ Fibromyalgia	☐ Peripheral Neuropathy (PN)
☐ Lower Back Pain	☐ Liver Disease
☐ High Blood Pressure	☐ Thyroid Disease
☐ High Cholesterol	☐ Hepatitis
☐ Heart Problems, Heart Attack ____Yes _____ No ☐ Do you have a Pace Maker ____Yes ____No	☐ Are you HIV positive? ______ Yes _______ No
☐ Arthritis	☐ History of Foot Ulcers

History of any other medical problems not listed? ____

____

Have you or a family member ever had a reaction to a local or general anesthetic? ____________________

____

Please list all major and minor **operations** you have had: ____

____

____

What is your main concern or complaint that you would like Dr. Sikoutris to address? ____________________

____

____

What size shoe do you wear? ____________________

Have you ever seen a Podiatrist before? ______________________ If so, when? ______________

Location: __________________ Treatment rendered: ______________________________