WEIL
FOOT & ANKLE INSTITUTE

(Please Print)

KIOSK REGISTRATION FORM

PATIENT NAME	BIRTH DATE / /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( ) -		
Street Address	City	State	Zip Code

REFERRING PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( ) -		
Street Address	City	State	Zip Code

SHOE SIZE	HEIGHT	WEIGHT

DO YOU DRINK?	☐ NO	☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO	☐ YES	PACK(S)/DAY

OCCUPATION

ADDITIONAL INFORMATION

Referral Source: _____

Email: _____

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Osco ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other _____

Address or Cross-Streets: _____

City: _____ State: __ Zip Code: _____

Phone Number: _____ Fax Number: _____

Authorization to Disclose Health Information:

I authorize (name)_____ (relationship)_____ to participate in my health care and have access to my health information.

Signature: _____