Dr. Larry J. Wapiennik & Dr. Larry J. Wapiennik, II
11406 Broadway, Crown Point, IN 46307

REGISTRATION UPDATE

Date_____ Home Phone_____ Work Phone_____ Email_____

Patient_____
Last Name First Name Initial

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured Name_____ REFERRED BY_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City_____ State_____ Zip_____
SPOUSE (PARENT)	Name_____ Last Name First Name Initial Birthdate_____ Social Security #_____ Employer Name_____ Occupation_____ Address_____ Phone_____ City_____ State_____ Zip_____
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials:_____ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Larry J. Wapiennik and/or Dr. Larry J. Wapiennik, II, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor(s). I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor(s) to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor(s) any and all plan documents, insurance policy and/or settlement information upon written request from such doctor(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor(s) to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor(s) and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor(s) in any attempts by such doctor(s) to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor(s) against such insurers and/or employee health care plan in my name but at such doctor(s) expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

Larry J Waplenik, DPM

PATIENT REGISTRATION

Name

Name _____ SS# _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars No. of years _____ How much? _____

Interested in stopping? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? _____

Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day? _____

Are you under a lot of pressure at work? ☐ Yes ☐ No Please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply):

☐ Chest pain/pressure/tightening _____	☐ Asthma _____	☐ Kidney disease _____
☐ Hypertension _____	☐ Dizzy spells _____	☐ Shortness of breath _____
☐ Heart attack _____	☐ Cancer _____	☐ TB/Lung disorder _____
☐ Stroke _____	☐ Diabetes _____	☐ Ulcers _____
☐ Headaches _____	☐ Arthritis _____	☐ Skin disorders _____
☐ Glaucoma _____	☐ Difficulty hearing _____	☐ Hepatitis _____
☐ Allergies or Eczema _____	☐ Glaucoma _____	☐ Cataracts _____
☐ Depression _____	☐ Memory loss _____	☐ Digestive problems _____
☐ Blood in stool _____	☐ Hemorrhoids _____	☐ Frequent urinary infections _____

☐ Other: _____

IMMUNIZATIONS

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
ECZEMA / PSORIASIS	☐	☐	☐	☐	☐	☐
HEART ATTACK / STROKE	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐
HAY FEVER	☐	☐	☐	☐	☐	☐