Choice Podiatry Center

Patient Registration Form

Date:_____
Patient:_____

Physical Address:_____ Sex: □ Female □ Male
_____ Birth Date:_____
Billing Address:_____ SS#_____
_____

Cell#:_____ Home #:_____
E-mail _____

Employer:_____ Occupation:_____
Address:_____ Employer's #:_____
_____

Ethnicity:_____ Race:_____
Preferred Language:_____

Primary Insurance _____ID#_____Group#_____Phone_____

Secondary Insurance_____ ID#_____Group#_____Phone_____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □
Spouse's Name_____

Do you currently have a living will/advanced directive/Durable Power of Attorney?

_____**Yes**, please circle all that apply _____**No**, Currently do not _____Decline to Disclose

IN CASE OF EMERGENCY CONTACT

Name:_____ Relationship:_____
Home Phone Number:_____ Cell Number:_____

Primary Care Physician Name:_____**Date Last Seen** _____

Address_____

HOW DID YOU FIND OUT ABOUT US?_____

Is there anyone beside yourself we can discuss your medical information with?

Yes, Please List_____ **No**_____

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SMOKING STATUS:

Current Every Day Smoker ☐
Current Some Day Smoker ☐ Frequency_____
Former Smoker ☐ How much_____
Never Smoked ☐
Unknown if Ever Smoked Smoker ☐
Do you drink? Yes ☐ No ☐ If yes, How Much_____
Do You Use Any Recreational Drug? Yes ☐ No ☐

Please place a mark if you or your family member has any of the following condition

Family History Guide

M-Mother F-Father S-Sibling U-Uncle A-Aunt GPA-Grandfather GMA-Grandmother

	Self	Family/Who		Self	Family/Who		Self	Family
AIDS/HIV	☐	☐____	Ear Problems	☐	☐____	Low Blood Pressure	☐	☐____
Anesthetics	☐	☐____	Epilepsy	☐	☐____	Phlebitis	☐	☐____
Anemia	☐	☐____	Eye Problem	☐	☐____	Psychiatric Care	☐	☐____
Angina	☐	☐____	Fainting	☐	☐____	Radiation Treatment	☐	☐____
Asthma	☐	☐____	Gout	☐	☐____	Respiratory Disease	☐	☐____
Back Pain	☐	☐____	Hammer Toes	☐	☐____	Shortness of Breath	☐	☐____
Bleeding	☐	☐____	Headaches	☐	☐____	Sinus Problems	☐	☐____
Disorder	☐	☐____	Heart Disease	☐	☐____	Skin Condition	☐	☐____
Cancer	☐	☐____	Hemophilia	☐	☐____	Special Diet	☐	☐____
Chest Pain	☐	☐____	Hepatitis	☐	☐____	Stroke	☐	☐____
Circulatory			High Cholest	☐	☐____	Tuberculosis	☐	☐____
Problems	☐	☐____	High Blood Pre	☐	☐____	Ulcers foot/leg/toes	☐	☐____
Diabetes	☐	☐____	Kidney Proble	☐	☐____	Varicose Veins	☐	☐____
Diarrhea	☐	☐____	Liver Disease	☐	☐____	Weight Loss (unexpl)	☐	☐____

None of the above conditions apply to myself _____
None of the above conditions apply to any member of my immediate family_____

PLEASE LIST ANY OTHER MEDICAL HISTORY NOT LISTED ABOVE

_____

PODIATRIC HISTORY

What is your chief complaint for which you came to be treated? _____
_____
_____
Athletic activities in which you participate:_____

SHOE SIZE:_____

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Have you ever been to be a Podiatrist before? Yes ☐ No ☐
If yes please list: Doctor's Name:_____Last Visit:_____

Please indicate which Foot or Leg problems you now have or have had in the past:

Ankle Pain	☐ Yes ☐ No	Ingrown Toenails	☐ Yes ☐ No
Athletes Foot	☐ Yes ☐ No	Swelling in Feet	☐ Yes ☐ No
Bunions	☐ Yes ☐ No	Swelling in Ankle	☐ Yes ☐ No
Corns/Callus	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No	Numbness	☐ Yes ☐ No
Plantar Warts	☐ Yes ☐ No	Fracture	☐ Yes ☐ No

Please list any Hospitalizations/Surgeries you had in the past _____
_____

Are you now, or have you been under any other doctors care for any reason over the past two years ☐ Yes ☐No
If yes, please explain:_____

MEDICATIONS: Include Prescription, over the counter and Vitamins:

_____
_____
_____

Pharmacy Name:_____Telephone Number:_____

Do you Consent for us to electronically retrieve your medication history? Yes / No

ALLERGIES:

No Known Allergies	Yes		Aspirin	Yes	No	Anesthetics	Yes	No
Adhesive Tape	Yes	No	Demerol	Yes	No	Iodine	Yes	No
Penicillin	Yes	No	Codeine	Yes	No	sulfa	Yes	No
Local Anesthetics	Yes	No	Novocain	Yes	No	Other_____		

_____

CONSENT

I certify that the above information is correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Name of the person filing out this form if not the patient_____

Patient/Guardian Signature_____ Date: _____

HIPPA Privacy

Choice Podiatry Center

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this acknowledgement of Receipt of Privacy Practices (the "Notice") I acknowledge and agree that I have received a copy or elected not to receive a copy of this notice of Privacy Practice for review and to keep for my records on the date identified below.

I understand that the CHOICE PODIATRY CENTER, INC may use and disclose necessary personal information (i.e., name, address, subscribers identification number, podiatry exam information and /or type of products provided) to another in-house employee to permit and perform its administration duties, provide me with podiatry services and products, process my podiatry benefit claims and communicate with me regarding podiatry care services provide by Choice Podiatry Center, Inc (i.e., mailing of exams, reminder information about services/products provided by Choice Podiatry Center, Inc.

I CAN BE ASSURED THAT CHOICE PODIATRY CENTER, INC WILL NOT SELL MY PERSONL INFORMATION OF ANY KIND TO A THIRD PARTY FOR SUCH PARTIES PERSONAL USE.

Choice Podiatry Center is to submit my podiatry benefit claim to my plan sponsor or health plan to receive reimbursement directly for the podiatry services and products that I received.

Please choose one of the following options:

_____ I do not want a copy of Choice Podiatry Centers HIPPA Privacy Practices

_____ I would like to receive a copy of Choice Podiatry Centers HIPPA Privacy Practices.

_____ _____

Patient Signature or Patient's Legal Representative Date

BILLING POLICY

REGARDING HMO'S, PPO'S and MANAGED CARE PROGRAMS:

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Patient Registration Form

We do not participate in some of these programs, so please check with your insurance company to see if we are providers for your particular plan. It is your responsibility to obtain all referral forms required by your insurance company. Please be aware that if you are seen by our doctor under an out of network insurance plan, you assume liability for the difference in coverage benefits. Some HMO/PPO/Managed Care Primary Care Physicians require all x-rays to be taken at their office so please check with your physician before your appointment.

COPAYS:

You will be expected to pay your co-pay at the time of your appointment. If you are unable to pay, you will be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE:

Payment is due at the time of service.

REGARDING PATIENTS WITH MEDICARE:

We will file all charges with Medicare and your supplemental insurance if applicable. If you do not have supplemental insurance, you will be billed for the 20% not paid by Medicare, or any deductible that has not been met.

MEDICAID DOES NOT COVER ALL PODIATRY SERVICES FOR INDIVIDUALS.

REGARDING WORKMEN'S COMPENSATION/AUTO/LIABILITY:

Our office requires authorization prior to the initial visit. If authorization has not been received by the time of your visit, our office will attempt to obtain it. If we do not receive authorization, then your personal health insurance information will be taken for filing purposes. You will be responsible for all fees until the case has been settled.

MINOR PATIENTS:

Patients under the age of 18 must have a parent and/or guardian accompany them to our office before treatment can be rendered. Arrangements must be made prior to being seen with the parent and/or guardian for any co-pays and payments to be made at the time of treatment.

LAB:

Our office uses an outside laboratory service. In the event that a lab test is performed, you will receive a separate bill for the lab services.

CUSTOM ORTHOTICS:

If your insurance does not cover orthotics or your deductible has not been met, a payment of half the price of the orthotics will be expected prior to ordering. The remaining half is due at the time your orthotics are dispensed.

It is always your responsibility to be sure that your account is settled, regardless of insurance or any other circumstances (such as litigation). The Patient is responsible for costs associated with collecting owed balances including but not limited to, collection agency fees, attorney fees, and court costs.

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Choice Podiatry Center.

I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Choice Podiatry Center. I also understand that if I fail to pay charges, I imply discontinuation of podiatry services.

_____ _____ _____

Signature Date

We require that you call at least 24 hours in advance. Appointments that are missed will accrue a fee of $25.00 that will be charged to the patient's account. Thank you in advance for your cooperation.