



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: _____

INSURANCE INFORMATION

Primary Insurance Carrier Name: _____ **ID NO:** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____
Relationship to Policy Holder: _____
Secondary Insurance Carrier Name: _____ **ID NO:** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____
Relationship to Policy Holder: _____

Marital Status: Single Married Widowed Separated Divorced

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** _____
Telephone Number: _____

Pharmacy Name: _____ **Telephone Number:** _____



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HOW DID YOU FIND OUT ABOUT US? _____

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

Yes, Please List _____ **No** _____

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

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



Patient Registration Form

What is your chief complaint for which you came to be treated? _____

Athletic activities in which you participate: _____

SHOE SIZE: _____

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



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diagnosis and/or treatment of my feet.

Name of the person filing out this form if not the patient _____

Patient/Guardian Signature _____ Date: _____

HIPAA Privacy

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 HIPAA Privacy Practices

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

Patient Signature or Patient’s Legal Representative

Date



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BILLING POLICY

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

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, you will be responsible for the charges associated with your visit. 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.



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**AUTHORIZATION OF PATIENT PICTURE, NAME AND AGE TO BE RELEASED
FOR THE SOLE PURPOSE OF MARKETING**

I _____ give permission to Choice Podiatry Center to use
Video and/or pictures in print for marketing and/or educational purposes.

**This consent may be withdrawn at any time. Withdrawal of consent must be writing to
Choice Podiatry Center physicians or practice manager.**

**I acknowledge that I have given my permission and understand that Choice Podiatry
Center will use my information regarding any surgical procedure and/or medical
treatments for the sole purpose of marketing and/ or educational purposes.**

Patient Name (print): _____ Date: _____

Patient Signature: _____

Parent or Authorized Representative Signature (if patient is a minor)

Date: _____