PREMIER PODIATRY GROUP

PATIENT REGISTRATION FORM

(PLEASE PRINT)

Patient Information

First Full Name:_____ MI:_____ Last Name:_____Gender: **M/F**

SSN#:_____ Date of Birth:_____ Age: _____ Marital Status: _____.

Address: _____.

City: _____ State: _____ Zip: _____.

Home Phone: _____Work Phone: _____Cell Phone: _____.

Primary Physician:_____Date Last Seen:_____Referred By: _____

Employer: _____Position:_____**Full Time/Part Time**

Business Address: _____

Chief Complaint: _____Occurrence Date: _____

Related to: Work: Yes/No Auto: Yes/No Accident: Yes/No Email Address: _____

Primary Insurance

Insurance Name: _____If necessary did you bring your referral: Yes/No/NA

Insurance Phone #: _____Policy/Member ID #: _____Group #: _____

Primary Insured's Full Name:_____Date of Birth:_____Gender: **M/F** SSN #:_____

Primary Insured's Home Address: _____

Employer's Name: _____Phone: _____

Employer's Address: _____

Secondary Insurance

Insurance Name: _____If necessary did you bring your referral: Yes/No/NA

Insurance Phone #: _____Policy/Member ID #: _____Group #: _____

Primary Insured's Full Name:_____Date of Birth:_____Gender: **M/F** SSN #:_____

Primary Insured's Home Address: _____

Employer's Name: _____Phone: _____

Employer's Address: _____

Privacy Information

Can we leave messages at any the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No
Emergency Contact Name:_____ Relationship:_____ Phone:_____
Names of family/friends who can pick up your records and/ medical supplies:_____
Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:_____
_____

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Doctors at Premier Podiatry Group.

Printed Patient's Name:_____ Signature:_____Date:_____.

Medical History

Welcome to our practice, as a new patient; please fill out the information below to the best of you ability.

General History

Full Name: _____ Occupation: _____

Gender: (circle) M or F Age: _____ DOB: _____ Weight: _____ Height: _____ Shoe Size: _____

Chief Complaint: _____ Family Doctor: _____Last Seen: _____

Would you say your health is: Good/Fair/Poor Do you think you might be pregnant? Yes/No

Smoking: Packs/day: _____ Years: _____ Past Smokers: Packs/days: _____ Years: _____

Caffeine: Quantity: _____ Alcohol: (circle) None Rarely Moderately Daily Quit

Recreational Drug Use: (circle) None Moderately Daily Quit

List Athletic activities: _____ Amount per day/week:_____

Employment requires you to: (circle which apply) Sit Stand Sit and Stand Stand and Walk Not Employed

Have you ever seen a podiatrist before: Yes/No. If yes, please list. Name: _____ Last Seen: _____

Have you ever worn orthotics/arch supports? Yes/No. If yes, what kind: _____

How did you hear about us? _____

Past Medical History: Do you have or ever had the following: (circle items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Cancer	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chest Pain	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Chemical Dependency	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in ankles/feet
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints(Location: _____?)	Depression	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes (Type I or II)	High Blood Pressure	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss, unexplained
				Hammertoes

Any other problems if so, what? _____

Sensation History: (circle) Night Pain Burning Tingling Swelling Cramps/Numbness in Feet or Legs Calf Pain

Pain Level: Please circle the number on the pain scale that best represents your level of pain at this moment.

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

(*zero: NO pain)* *(ten: Worst possible pain)*

Previous Hospitalizations/Surgeries/serious Illnesses	Date	Hospital, City, ST
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Blood Transfusions: Yes/No Exposure to Hepatitis: Yes/No

Medications (please attach additional list if necessary)

Include prescriptions, over-the-counter medications and vitamins:

_____

_____

Pharmacy Name: _____ Location: _____ Phone #: _____

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **NO KNOWN ALLERGIES**

Adhesive/Tape: _____	Anticoagulants: _____	Aspirin: _____
Codeine: _____	Demerol: _____	Iodine: _____
Local Anesthetics: _____	Novocain: _____	Penicillin: _____
Seafood: _____	Sulfa: _____	Other: _____

Family Medical History:

	Age	Diseases (diabetes, heart, vascular, neurological, etc.)	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Print Patient's Name: _____ Signature: _____ Date: _____

REVIEW OF SYSTEMS

Please answer to the best of your ability.

Constitutional Symptoms

Good general health lately……no yes
Recent weight change……no yes
Chills……..no yes
Fever……..no yes
Night sweats..……no yes
Fatigue……...no yes

Cardiovascular

Heart trouble……no yes
Chest pain……..……..no yes
Shortness of breath with exertion….no yes
Swelling of feet ankles, hands……..no yes

Respiratory

Frequent cough…….no yes
Shortness of breath……...….no yes

Integumentary (Skin)

Rash or itching…….…no yes
Change in hair or nails……no yes
Varicose veins…….no yes

GI

Abdominal pain ……..…..no yes
Heart burn ……no yes
Vomiting ……..no yes
Yellowing of the skin ……..no yes
Bowel habit change ……no yes

GU

Kidney dialysis ……no yes
Increased urinary frequency …..….no yes
Currently pregnant ……..no yes

Eyes

Loss of vision …….no yes
Blurred vision ……no yes
Photosensitivity ……..no yes

Psychiatric

Memory loss ……no yes
Panic attack …… no yes
Any other psychiatric disorder ……no yes

Neurological

Lightheaded or dizzy……..no yes
Numbness or tingling……..no yes
Paralysis……..no yes

Endocrine

Glandular or hormone problem…….…..no yes
Excessive thirst or urination……no yes

Hematologic/lymphatic

Slow to heal after cuts……no yes
Bleeding or bruising tendency……...….no yes
Anemia……no yes
Phlebitis…….…..no yes
Past Transfusion……..no yes
Enlarge glands…….no yes

Musculoskeletal

Joint pain……...…..no yes
Joint stiffness or swelling……...….no yes
Weakness of muscles or joints……..….no yes
Back pain……..…no yes
Cold extremities…….……..….no yes

Ear, Nose, Mouth, Throat

Difficulty swallowing …….……..no yes
Difficulty hearing ……...…..no yes

Immunologic

Arthritic flare up ……no yes
Hepatitis B carrier ……..no yes
HIV carrier ……no yes
Seasonal allergies ……..……no yes

Allergies

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotic……no yes
Novocain or other anesthetic…….…..no yes
Aspirin or other pain remedy…...……no yes
Codeine or other narcotic…….no yes
Betadine/iodine or other antiseptic…..…no yes
Other drugs or medication:

_____
_____

Other food or environmental allergies:

_____
_____

_____
Signature of patient or guardian Date

_____
Signature of Doctor

Please thoroughly read each Premier Podiatry Group policy.

Treatment Agreement

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

For the purpose of payment, I allow **Premier Podiatry Group** to release my Private Health Information to any and all of my insurance carriers, their third payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all my treating physicians.

I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff and other patients.

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose so) and understand the Notice. The HIPPA rights are also posted in the lobby.

Patient Financial Policy

I must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc.) to the office prior to your appointment.

I am responsible for **all authorizations/referrals/precerts** needed to seek treatment with **Premier Podiatry Group's** physicians.

My portion of payment for ALL office services is due at the time of service. We will accept credit cards, cash or check. Your insurance policy is a contract between you and your insurance company. As a **courtesy**, we will file your insurance claim for you. When you do an assignment of benefits, you are agreeing to have your insurance company pay your doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

Please honor our 24 hours reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the co-pay/co-insurance/deductible at the time of service.** If you are seeing our doctors on a "Out of Network" basis, you will be subject to out of network rates. Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized: however, you remain responsible for charges to any service rendered. **Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.**

Our office does not file secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your **designated** PRIMARY policy.

Pre-scheduled Surgical procedures require pre-payment/estimated deposit. **Your deductible/co-pay for this procedure is due at the pre-operative appointment.** For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. There is a $100.00 non-refundable clerical fee for surgeries not cancelled two weeks in advance. We suggest you carefully select your surgical date to avoid this charge. It is your responsibility to obtain an adult to transport you to and from surgery and remain with you for 24 hours.

PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance of the office.

Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the **Premier Podiatry Group** relationship.

There is a service fee of $30.00 for all returned checks.

ONLY UNWORN and NON-custom items are returnable within 5 days of receipt. Custom items such as orthotics are non-refundable.

Authorization of Payment

I hereby assign all Medical benefits directly to **Premier Podiatry Group** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor. Suggestions and or grievances can be directed to the doctor via telephone, letter or email.

Patients Name _____

Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received

My signature authorizes the assignment of benefits to **Premier Podiatry Group** and will remain on file until further written notification.