

PODIATRIC REGISTRATION AND HISTORY

Memorial Podiatry Group

1. PATIENT INFORMATION

Date _____
Patient: _____
Address: _____

City _____ State _____ ZIP _____
Sex M F Date of Birth _____
Patient SS#: _____
Occupation _____
Employer: _____
Emp Address _____

City _____ State _____ ZIP _____
Spouse Name _____
DOB: _____ SS#: _____
Employer: _____
Who may be thanked for referring you?

3. PHONE NUMBERS

Daytime _____
Home _____ Work _____
Email Address: _____
In case of Emergency:
Name: _____ Ph#: _____

4. HEALTH HISTORY

Chief Complaint? How Long have You Had It?

Previous Treatment Received? _____

Is there family history of Diabetes? yes no
Do You Smoke? yes no Years Smoked _____

What Athletic Activities do you participate in?

2. INSURANCE INFORMATION

Who is Responsible for Account? _____
Relationship to Patient _____

Primary Insurance Company _____
Address: _____

Subscriber ID#: _____
Group #: _____
Subscribers Name _____
Date of Birth _____
Relationship to Patient _____

Secondary Insurance Company _____
Address: _____

Subscriber ID#: _____
Group #: _____
Subscribers Name _____
Date of Birth _____
Relationship to Patient _____

AUTHORIZATION:

I authorize the payment of authorized services by my insurance company listed above to be made on my behalf to Memorial Podiatry Group. I authorize the release of my medical information necessary to process such claims. I realize that I am responsible for deductible, co-payments and co-insurance as well as any and all non-covered services.

Authorized Signature _____

Date _____

5. PODIATRIC COMPLAINTS

Ankle Pain	_____ yes	_____ no
Athletes Foot	_____ yes	_____ no
Bunions	_____ yes	_____ no
Corns and Calluses	_____ yes	_____ no
Foot/Leg Cramps/Numbness	_____ yes	_____ no
Flat Feet	_____ yes	_____ no
Heel Pain	_____ yes	_____ no
Ingrown Toenails	_____ yes	_____ no
Plantar Warts	_____ yes	_____ no
Swelling in Ankles or Feet	_____ yes	_____ no

6. ALLERGIES

- Adhesive Tape
- Penicillin
- Aspirin
- Iodine (Seafood)

Narcotics (If yes, please explain) _____

Other _____

7. MEDICAL HISTORY

Place YES or NO to indicate if you have now or have had any of the following:

AIDS/ HIV	YES	NO	Diabetes	YES	NO	Rheumatic Fever	YES	NO
Allergies to Anesthesia	YES	NO	Epilepsy	YES	NO	Shortness Breath	YES	NO
Allergies to Medicine or Drugs	YES	NO	Foot or Leg Cramps	YES	NO	Sinus Problems	YES	NO
Anemia	YES	NO	Gout	YES	NO	Stroke	YES	NO
Angina	YES	NO	Headaches	YES	NO	Tuberculosis	YES	NO
Athritis	YES	NO	Heart Disease	YES	NO	Ulcers	YES	NO
Artificial Heart Valves/Joints	YES	NO	Hemophilia	YES	NO	Varicose Veins	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO	Venereal Disease	YES	NO
Back Problems	YES	NO	High Blood Pressure	YES	NO	Weight Loss (unexplained)	YES	NO
Bleeding Disorders	YES	NO	Kidney Problems	YES	NO			
Cancer	YES	NO	Liver Disease	YES	NO			
Chemo Therapy	YES	NO	Low Blood Pressure	YES	NO			
Chemical Dependency	YES	NO	Nervous Problems	YES	NO			
Chest Pain	YES	NO	Phlebitis	YES	NO			
Chronic Pain	YES	NO	Psychiatric Care	YES	NO			
Chronic Diarrhea	YES	NO	Rash	YES	NO			
Circulatory Problems	YES	NO	Respiratory Disease	YES	NO			

Surgeries you have had _____

Hospitalizations other than for surgeries listed above _____

Primary Care Physician _____

Are you now or have you been under the care of a doctor for the last two years? _____

If Yes, please explain _____

8. MEDICATIONS

Include Prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name and Phone Number _____

Do you Take Hormone Replacement/Oral Contraceptives? ___ YES ___ NO

9. CONSENT

I Certify that the above information is true and 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.

Patient/Guardian Signature _____ Date _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

This Notice of Privacy Practices contains a detailed description of how our office will protect you patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information.

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Use and Disclosure Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purposes of public health and safety

- To Government agencies for purposes of their audits, investigations and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights. As our patient you have the following rights:

- To have access to and/or a copy of you health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with our in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGE OF RECEIPT of NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Print Patients Name _____ Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____