New Patient Registration Form

Patient Information

Patient Name:			Date of Birth:
Sex: Male ☐ Female ☐	Social Security #:	Employed: Yes ☐ No ☐	Occupation:
Address: Street, City, Zip Code			
Cell #:		Home #: Work #:	
Email:		Marital Status: Married☐ Single☐ Divorced☐ Widowed☐ Partnered☐	
Emergency Contact Name/Relationship:			Phone #
Primary Physicians Name:			
Physician Contact Number:			Date Last Seen:

Insurance Information

Primary Insurance Name:	ID #:
Policy Holder's Name:	Date of Birth#:
Secondary Insurance Name:	ID #:
Secondary Policy Holder's Name:	Date of Birth#:
Relationship to Primary/Secondary Policy Holder:	

How did you hear about us? Physician☐ Internet ☐ Social Media☐ Insurance☐ Family/Friend☐

Referring Physician's Name:

Referring Friend/Family's Name:

Patient's Medical History

Patients Name: | **Shoe Size:**

Reason for your visit: | **Pain Level:**

Height: | **Weight:** | **Alcohol Intake**: No ☐ Yes ☐, If Yes, How Often?

Smoker: No ☐ Yes ☐ pack(s)/day X years | **Previous Smoker**: No ☐ Yes ☐; How much/long:

Constitutional: Are you currently experiencing: Nausea ☐ Vomiting ☐ Fever ☐ Chills ☐ Night Sweats ☐ Rash ☐ Peeling Skin ☐ Itching ☐ Blisters ☐ Bruises ☐ Brittle Hair Loss ☐ Cold Toes/Color Changes ☐ Numb feet/legs ☐ Leg pain while walking ☐ Swelling ☐ Burning feet/legs ☐ Tingling feet/legs ☐

Allergies: No Known Drug Allergy ☐ Yes ☐ If Yes, please list name/reactions:

Pharmacy Name: | **Pharmacy City:**

Medication(s): List current medications & dosage:

Past Medical History: If you now have or have ever had any of the following conditions:

☐ ADD/ADHD	☐ Cancer________________	☐ Hepatitis _____	☐ Neurological Disorder
☐ Alcohol/Drug Dependency	☐ Circulation Issues.	☐ High Blood Pressure	☐ Osteoarthritis
☐ Alzheimer's/ Dementia	☐ Currently Pregnant	☐ Hypothyroid	☐ Osteoporosis
☐ Anemia	☐ Diabetes Type I or Type II	☐ Immune Disease	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Dialysis	☐ Kidney Disease	☐ Skin Disease
☐ Asthma	☐ Depression	☐ Liver Disease	☐ Stomach Ulcer
☐ Back Problems	☐ Gout	☐ Lung Disease.	☐ Other
☐ Bleeding Disorder	☐ GI Disease	☐ Lymphedema	
☐ Bipolar Disorder	☐ Heart Attack/Disease	☐ Metal Allergy	

If Diabetic, How many years since diagnosis: | Last HgA1c: ; Blood Sugar: | Date:

Who manages your diabetes? | Phone #:

Family History: Please check any pertinent medical condition that runs in your family & write which member(s) affected:

☐ Diabetes ☐ Gout ☐ Heart Disease ☐ Hypertension
☐ Other

Surgeries: List all surgeries you have had. Begin with the most recent. List the year.

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor(s) deems necessary.

____ ________________

Signature of Patient, Parent, Guardian, or Personal Representative Date

____ ________________

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to provide you, or allow your review if, the Notice of Privacy Practices of Advanced Foot Specialists, which states how we use and/or disclose your Protected Health Information (PMI).
In review, some of the ways we use and/or disclose your PHI are for the following purposes:

- Treatment: we may disclose information necessary for your medical treatment and care. We may disclose information to those involved in your healthcare (ex. physicians, family members, pharmacies, labs, etc.)
- Payment: we may disclose information needed to file claims and bill for medical services
- Health care operations: we may disclose PHI to carry out certain health care operations (ex. surveys, etc.)
- Public health

In order for us to be able to share this information with others, we need you to list the people we may contact.

I, ______________________________ give permission to Advanced Foot Specialists, to disclose PHI to:

____.

For written communications: ☐ Home Address ☐ Work Address ☐ Other Address ___________

For oral communications: ☐ Home Number ☐ Cell Number ☐ Work Number ☐ Other___________

I hereby by acknowledge receipt of the Notice of Privacy Practices of Advanced Foot Specialists or have had the opportunity to review the Notice and accept it as written.

Signature: ____

Date: ____

Financial Responsibilities/Policies

At Advanced Foot Specialists, we strive to give you the best care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of your service. Understand that you will be expected to pay your co-payment for each and every date of service.
- You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment in the office.
- If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; 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.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due to their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness of all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You will be asked to pay before you are seen by the doctor.

Signature of Patient/ Responsible Party:____ **Date:**____________

Printed Name of Patient/ Responsible Party: ____**Date:**____________