

## Ankle & Foot Care Centers PATIENT REGISTRATION FORM

**Patient Information:**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Today's Date: \_\_\_\_\_ M.I. \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex (circle): Male Female Marital Status (circle): Married Single Divorced Widowed Separated

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone #: (\_\_\_\_) \_\_\_\_\_

**Spouse or Parent (if patient is a minor):**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

**Referral Information:** How did you find out about us? (please check appropriate box)  previous patient

- |   |  |
|---|--|
| <input type="checkbox"/> Family/Friend  | <input type="checkbox"/> Phone Book    |
| <input type="checkbox"/> Dr. _____      | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Hospital _____ | <input type="checkbox"/> TV/Radio Ad   |
| <input type="checkbox"/> Insurance Book | <input type="checkbox"/> Building Sign |
| <input type="checkbox"/> Newspaper Ad   | <input type="checkbox"/> Other _____   |

**Insurance Information (must be completed to bill insurance):**

Name of Primary Insurance: \_\_\_\_\_ (need copy of insurance card)

Name of Policyholder (person who actually has the insurance coverage): \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ Policyholder's SSN # \_\_\_\_\_

Patient Relationship to Policyholder: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_ (need copy of insurance card)

Name of Policyholder (person who actually has the insurance coverage): \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ Policyholder's SSN # \_\_\_\_\_

Patient Relationship to Policyholder: \_\_\_\_\_

Are you seeking this treatment for a Worker Compensation injury? Yes No

If "Yes" has your employer been notified? Yes No

Workman's Comp. Claim #: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Chief Complaint: What is the reason for the visit? \_\_\_\_\_

Duration of Problem: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Any Previous Treatment? Yes / No What type? \_\_\_\_\_ By Whom? \_\_\_\_\_

**Social History:**

|                      |       |    |                  |                   |
|----------------------|-------|----|------------------|-------------------|
| Tobacco Use:         | Yes   | No | Packs/day _____  | # of years: _____ |
| Alcohol Use:         | Yes   | No | Drinks/day _____ | # of years: _____ |
| Illicit Drug Use:    | Yes   | No | Type: _____      | # of years: _____ |
| Athletic Activities: | _____ |    |                  |                   |

**Past Medical History:**

Do you or have you had any problems with (check all that apply):

|                                       |                                      |                                   |   |
|---------------------------------------|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Heart        | <input type="checkbox"/> Circulation | <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Bladder        |
| <input type="checkbox"/> Lungs        | <input type="checkbox"/> Head        | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Prostate       |
| <input type="checkbox"/> Liver        | <input type="checkbox"/> Eyes        | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovaries/Uterus |
| <input type="checkbox"/> Kidneys      | <input type="checkbox"/> Ears        | <input type="checkbox"/> Stomach  | <input type="checkbox"/> Bones/Joints   |
| <input type="checkbox"/> Other: _____ |                                      |                                   |   |

Past Surgeries/Hospitalizations: \_\_\_\_\_

Allergies & Reactions: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Current Medications (Including prescriptions, over-the-counter, and vitamins):

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family Medical History:** Please check (v) those family members that have any of the conditions listed below:

| Condition           | Mother | Father | Brother | Sister | Grandmother | GrandFather | Aunt | Uncle |
|---------------------|--------|--------|---------|--------|-------------|-------------|------|-------|
| Arthritis           |        |        |         |        |             |             |      |       |
| Asthma              |        |        |         |        |             |             |      |       |
| Cancer              |        |        |         |        |             |             |      |       |
| Diabetes            |        |        |         |        |             |             |      |       |
| Hemophilia          |        |        |         |        |             |             |      |       |
| Heart Disease       |        |        |         |        |             |             |      |       |
| High Blood Pressure |        |        |         |        |             |             |      |       |
| Kidney Disease      |        |        |         |        |             |             |      |       |
| Liver Disease       |        |        |         |        |             |             |      |       |
| Low Blood Pressure  |        |        |         |        |             |             |      |       |
| Stroke              |        |        |         |        |             |             |      |       |
| Thyroid Disease     |        |        |         |        |             |             |      |       |
| Tuberculosis        |        |        |         |        |             |             |      |       |
| Other _____         |        |        |         |        |             |             |      |       |

**Signature on File & Permission to Treat:**

I request that payments of authorized benefits be made on my behalf for any services furnished by **Ankle & Foot Care Centers**. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Ankle & Foot Care Centers to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of foot and/or ankle problems for myself or as legal guardian for the patient.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient or Legal Guardian

**FINANCIAL POLICY**

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payments. To ensure quality communication, it is the patient's and/or guardian's responsibility to inquire about fees/insurance coverage prior to any service being performed. We accept many different insurance plans; however, all health plans are not the same and do not cover the same services. It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy service which we are happy to provide; however, Ankle & Foot Care Centers is **NOT** held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet or call your insurance plan for a detailed outline of your benefits.

**-Managed Care/Private Insurance Patients**

If you are in a managed care plan (e.g., HMO/PPO) with whom we participate, we abide by our contract with them. We will bill your insurance company; however, you are responsible for paying any co-pays, co-insurance, and deductibles required by your plan at the time of treatment.

**-Medicare Patients**

We accept assignment. This does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

**-Uninsured Patients**

A minimum payment of \$65 is due at the time of service. Additional charges may apply.

**-All Patients**

For your convenience we accept: Visa, Mastercard, American Express, Discover, cash, or check. There is a service fee of \$25 for all returned checks.

***Please note: It is the responsibility of each patient to know their contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patient's responsibility to obtain that referral, or have it sent to our office, prior to obtaining services from Ankle & Foot Care Centers.***

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Legal Guardian

**PRIVACY PRACTICES**

Ankle & Foot Care Centers will use and disclose your health information for the following purposes: treating you, assisting other health care providers in treating you, allowing insurance companies to process insurance claims for services rendered, obtaining payment for services rendered to you, and for certain operational activities such as quality assessment, licensing, accreditation, and training of students. 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. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you.

**Additional Disclosure Authority:** In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below (please provide name & phone #):

|     |    |         |       |
|-----|----|---------|-------|
| Yes | No | Mother  | _____ |
| Yes | No | Father  | _____ |
| Yes | No | Sister  | _____ |
| Yes | No | Brother | _____ |
| Yes | No | Spouse  | _____ |
| Yes | No | Other   | _____ |

I acknowledge that I was provided a copy of the Notice of Privacy Practices, have read, or had the opportunity to read, and understand the Notice.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Legal Guardian