Patient Registration Form

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Gender: _____ **Date of Birth:** _____

Address: _____ **Zip:** _____ **City:** _____ **State:** _____

Home Phone: _____ **Mobile phone:** _____ **Work phone:** _____

Consent to text: ☐ Yes ☐ No

Email: _____

Contact Preference: (Circle One) Home Mobile phone Work phone Patient portal

Language: _____ **Race:** _____ **Ethnicity:** Hispanic Non- Hispanic

Marital Status: (Circle One) Married Widowed Divorced Separated Single

Occupation: _____

How did you hear about us?: (circle one) Billboard Newspaper Patient Internet Physician Other: _____

Emergency Contact: **Last Name:** _____ **First Name:** _____

Relationship: _____ **Phone Number:** _____

Physician Information:

Primary Care Doctor: _____ Date last seen: _____

Address: _____

Guarantor Information: ***IF PATIENT IS UNDER 18 YEARS OF AGE****

First Name: _____ Last Name: _____ Middle Initial: _____

SSN: _____ Date of Birth: _____

Address: _____ Zip: _____ City: _____ State: _____

Home Phone: _____ Mobile phone: _____ Work phone: _____

Insurance Information:

Primary Insurance

Insurance Name: _____

Insurance ID#/Group #: _____

Subscriber Information: **Self** (Leave blank if self)

Name: _____

Date of birth: _____

Address:

_____

Phone number: _____

Secondary Insurance

Insurance Name: _____

Insurance ID#/Group #: _____

Subscriber Information: **Self** (Leave blank if self)

Name: _____

Date of birth: _____

Address:

_____

Phone number: _____

Past Surgical History:

Medications:

Allergies: (circle all that apply)

No Known Drug Allergies	Aspirin	Cortisone	Iodine/Betadine	Novocain/Lidocaine
Penicillin	Sulfa	Latex	Tape/Adhesive	Other:_____

Past Medical History: (check all that apply)

- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Back pain
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Breathing problems
- ❑ Cancer
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Dementia
- ❑ Diabetes Type _____
- ❑ Dialysis
- ❑ Difficulty healing
- ❑ Edema
- ❑ Fibromyalgia
- ❑ Foot Deformity
- ❑ Gout
- ❑ HIV/AIDS
- ❑ Headaches/Migraines
- ❑ Heart disease
- ❑ Hepatitis Type _____
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Leg/foot ulcerations
- ❑ Liver disease
- ❑ Lung disease
- ❑ Neuropathy
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Psychiatric disorder
- ❑ Raynaud's Disease
- ❑ Rheumatoid arthritis
- ❑ Seizures/Epilepsy
- ❑ Stroke
- ❑ Substance Abuse
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Varicose veins
- ❑ Other: _____

Social History:

Do you smoke?:	❑ Never	❑ Former	❑ Current	How much? _____
Do you drink alcohol?:	❑ Never	❑ Occasional	❑ Daily	How much? _____
Do you use recreational drugs?:	❑ No	❑ Yes		

Family History: (ie: heart disease, cancer, diabetes)

_____

Preferred Pharmacy: _____ Location: _____

What is your main concern with your feet today?:

_____

Height: _____ Weight: _____ Shoe Size: _____

Premier Ankle & Foot Specialists, PC

Consent for assignment of benefit and treatment

I certify that my dependent(s) and I have insurance coverage with the above referenced insurance carrier. I hereby authorize the release of all medical information necessary to process the insurance claim(s). I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Premier Ankle & Foot Specialists, PC.

Premier Ankle & Foot Specialists, PC and it's agents may use my health care information and may disclose such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I grant permission for the above named doctor and their assistants to render care in the diagnosis and/or treatment of my foot conditions. I also grant permission for release of information to my physician and/or emergency medical personnel as required by law.

This assignment will remain in effect until revoked by myself in writing. A signed photocopy of this assignment will be considered as valid as an original.

Signature of responsible party: _____ Date: _____

Printed name: _____

Patient name (if different from responsible party): _____

Acknowledgement of receipt of financial policy:

I acknowledge that I have read and I understand the financial policy. I understand the financial policies and fully accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature of responsible party: _____ Date: _____

Printed name: _____

Patient name (if different from responsible party): _____

Acknowledgement of receipt of notice of privacy practices:

I acknowledge that I was provided a copy of the notice of privacy practices. I have read and understand the notice. By signing this form, I am consenting to Premier Ankle & Foot Specialists, PC, and disclosure of my health information to carry out treatment, payment and healthcare operations.

Signature of responsible party: _____ Date: _____

Printed name: _____

Patient name (if different from responsible party): _____

Premier Ankle & Foot Specialists PC

Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: _____

Release of Information

☐ I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse: _____

☐ Children: _____

☐ Other: _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

No Show/Late POLICY

Premier Ankle & Foot Specialists, PC

A patient will be considered a “no show” if an appointment is missed or cancelled with less than 24 hours notice. When this occurs, our facility loses the opportunity to care for other patients. If 24 hours notice is not received, a fee of $25.00 will be charged to your account. This fee is not covered by insurance, and is therefore the sole responsibility of the patient. We also reserve the right to dismiss you as a patient for excessive “no shows” or cancellations with less than 24 hours notice.

A patient who is 15 minutes or more late for an appointment, may be asked to reschedule. By being late, it does affect other patients' care.

I, _____ understand and acknowledge that Premier Ankle & Foot Specialists, P.C. has a policy to charge me a $25.00 fee if I fail to show up for a scheduled appointment. I agree to pay this fee if necessary, and understand that I will be unable to schedule future appointments until the fee is paid. It is therefore my responsibility to keep track of the appointments I schedule, and is not the facility’s responsibility to notify me of upcoming appointments. I am aware that if I am late for my appointment, I may be asked to reschedule and the fee does apply.

_____ Responsible Party’s Signature

_____ Today’s Date