FREDERICK FOOT & ANKLE

877.668.0008 www.mynewfeet.com

Podiatric Medicine | Foot & Ankle Surgery | Sports Medicine | Wound Care | Physical Therapy

PATIENT REGISTRATION

Name: Last, First, MI: _____

Date of Birth: _____ Sex: ☐Male ☐Female Gender Identity if different from sex: _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native HI /Other Pacific Islander ☐White ☐Other

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino Preferred Language: _____

Social Security Number: _____ Martial Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Frederick Foot and Ankle can contact/leave a message: ☐Home Phone ☐Cell Phone ☐Email

Employer: _____

Spouse/Parent/Guardian: _____ Phone: _____

Second Parent/Guardian: _____ Phone: _____

How did you hear about our practice? Check all that apply.

☐Facebook ☐Online ☐Saw Truck ☐Keys Game ☐Newspaper ☐Key 103 ☐99.9 WFRE ☐TV Ad

☐Friend/Family: _____ ☐Doctor: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____

Insurance Information I have the following insurance (check all that apply).

☐Medicare ☐Medicaid ☐Other State Insurance ☐Tricare (any) ☐Other insurance (BCBS, Aetna, Cigna, UHC, etc.)

□ Worker's Comp/Auto We require adjustor's information and claim number

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Assignment of Benefits and Authorization to Release Medical Information: I understand and agree that payment of authorized benefits under Medicare, Medicaid and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of medical information about to me to release it to Frederick Foot and Ankle (FFA), the Health Care Financing Administration, listed insurer of the company and/or listed responsible persons and any information necessary to determine my benefits. If my insurance plan does not participate with FFA, or if I am a self pay patient, assignment of benefits may not apply.

Consent to Treatment: As a patient of FFA, I voluntarily consent to the rendering of such care and treatment as the providers of FFA in their clinical judgement deem necessary for my health and well being. My consent shall include medical examination, diagnostic testing, including, but not limited to, minor surgical procedures (including suturing, debridement), cast application/removals, administration of injections. My consent shall also include the carrying out of the orders of my treating provider by FFA staff. I acknowledge that FFA providers have not made any guarantees or promises as to the results that may be obtained.

Patient of FFA have the Right to: Privacy; be treated with dignity and respect regardless of race, national origin, religion, physical handicap, gender identity, sexual orientation or source of payment; be given information about your healthcare and treatment options; be involved in decisions regarding the care you receive; refuse any treatment; access your medical records in accordance with HIPAA standards; information about the cost of care and to participate in discuss treatment options regardless of cost or benefit coverage.

Patients of FFA have the Responsibility to: Be on time for appointments or cancel 24 hours in advance; comply with the agreed upon treatment plan; be honest with their provider; respect the rights of fellow patients; treat FFA providers and staff with respect and dignity; report changes in address, phone numbers and insurance; obtain referrals if required. Patients who neglect their responsibilities may be discharged from the practice following notification in accordance with local laws.

I hereby acknowledge that I have reviewed FFA's *Financial Policy* and *Notice of Privacy Practices* . I agree to the terms of the Financial Policy and consent to treatment by providers of FFA.

Patient Name: _____

Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

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CLINICAL REGISTRATION FORM

We require this form to be completed for all new patients and <u>every year</u> for current patients.

What is the main reason for your visit today: _____

When did your symptoms start? _____

Do you have a secondary reason for your visit today? _____

If here for injury, date and place of injury: _____

Is injury related to: □ Work □ Auto If yes, please let the receptionist know. We will need additional information.

Primary Care Physician: _____ Date of last physical: _____

List all allergies: _____ □ I have no allergies

Are you allergic to latex: □ Yes □ No Women: Are you pregnant? □ Yes, _____ weeks □ No

Do you have or have you ever had any of the following conditions: ☐ I have no medical conditions

□ Anemia	□ Arthritis	□ Bleeding Disorders	□ Cancer
□ Diabetes	□ Heart Disease	□ Heart Disease	□ High Blood Pressure
□ High Cholesterol	□ HIV/Aids	□ Kidney Disorder	□ Liver Disorder
□ Neurological Problems	□ Respiratory Problems	□ Stomach/Intestinal Problems	□ Thyroid Problems

□ Other: _____

List any **foot/ankle** surgeries: _____

List any other surgeries: _____

Please list all medications, vitamins and supplements you take, as well as the condition they are for. If you have a paper list, the receptionist can make a copy and attach it for you ☐ I do not take any medications

Medication/Vitamin	**Condition/Reason**

Are you taking any blood thinners? □ Yes □ No Have you been hospitalized in the last 5 years? □ Yes □ No

Any other medical conditions the doctor should be aware of: _____

Do you currently have any of the following symptoms? (please circle)

<u>Constitutional</u>	<u>Cardiovascular</u>	<u>Musculoskeletal</u>	<u>Dermatological</u>	<u>Neurological</u>
Chills	Edema/Swelling	Ankle Pain Foot Pain	Itchy Feet Skin Ulcer	Burning to Feet
Fever	Hair loss on legs	Arthritis Heel Pain	Nail fungus Warts	Numbness in Feet
Nausea	Leg/foot cramps	Back Pain Knee Pain	Calluses/Corns	Tingling in Feet
Fatigue	Legs/feet cool to touch	Bunions Toe Pain	Lumps/Bumps on Legs or feet	
Vomiting	Varicose Veins	Hammertoes	Ingrown Nails	
Unexplained Weight Loss/Gain		Restricted motion to foot/ankle joints		

Social: Do you smoke: □ Yes □ No How many packs/day? _____ Have you previously smoked? □ Yes □ No

Do you consume alcoholic drinks? □ Yes □ No How often/much? □ 1 drink/week □ 3 drinks/week □ Daily □ Excessive

Do you use recreational drugs? □ Yes □ No Please list: _____

Family History: ☐ I have no family medical history

□ Anesthesia Problems	□ Bleeding Disorders	□ Diabetes	□ High Blood Pressure
□ Arthritis	□ Cancer	□ Heart Disease	□ Other: _____

Any other health history or pertinent medical information: _____