

CLINICAL REGISTRATION FORM

We require this form to be completed for all new patients and every year 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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> 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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |

Any other health history or pertinent medical information: _____

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

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.

Patients 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: _____ Date of Birth: _____

Signature: _____ Date: _____

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