Date_____ **PodiatryCare, PC** *and the* **Heel Pain Center** Acct. #_____

Patient Registration

Last Name _____First Name _____MI ____

Street _____Apt # ____City _____ State___Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____ext ____

Date of Birth ___/ ____/ ____ Age ____ Sex _____ Marital Status S__ M __ W__ D__ Other __

Occupation _____ Employer_____ Retired___

Race: Caucasian ___African American___ Other ___ _____Non Hispanic __Hispanic___ Preferred Language:_____

Hand Dominance: R __ L __ Preferred Mode of Communication Phone__ Cell__ Mail __ E-Mail__

E-Mail_____Local Pharmacy and Location_____

Emergency Contact_____Phone _____Relationship_____

Primary Care Physician _____City/Town_____

Who may we thank for referring you? _____

Primary Insurance_____

ID # _____ Group # _____

Subscriber Name _____ DOB _____

Patient Relationship Self___ Spouse___ Child ___ Other___

Secondary Insurance_____

ID# _____Group # _____

Subscriber Name _____ DOB _____

Patient Relationship Self ___ Spouse ___ Child ___ Other___

Reason for today's visit _____

Family History (Blood Relatives) – Please check all that apply

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis						
Bleeding Disorder						
Bunions						
Circulatory Problems						
Diabetes						
Flat Feet						
Hammertoes						
Heart Disease						
Neurologic Disorders						
Stroke						

Name_____ Acct # _____

Height_____**Weight**_____ **Shoe Size** _____

Please check if any of these are applicable to you:

___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Circulatory Disease
___ COPD
___ Diabetes
___ Insulin Dependent Y __ N __
___ Gout
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Neurological Disorder
___ Rheumatoid Disorder
___Stomach Ulcers
___Thyroid Disorder
___**Other** _____

___ **NONE of the above conditions apply**

Allergies (check or note all that apply to you)

___ **NO KNOWN DRUG ALLERGIES**

. . Antibiotics _____
. . Aspirin
. . Betadine (Iodine)
. . Codeine
. . Ibuprofen (Advil, Motrin)
. . Latex
. . Local anesthetics (Novocaine, Lidocaine)
. . Penicillin
. . Seafood
. . Sulfa
. . Other _____

Medications/vitamins/supplements with dosages

_____
_____
_____
_____
_____
_____

See my list ____ No Medications ____

Do you smoke? Y__ N__ # of packs per day ____ Are you a previous smoker? Y__ N__ # of packs per day ___
Do you drink alcohol? Y___ N___
Have you had any major surgeries in the last 5 years? Y___ N___ If yes, what type_____

Do you have any artificial joints Y ___ N ___ Location _____ Do you have a heart valve implant? Y ___ N___

____**(Initials)** I request that payment of the authorized benefits be paid either to me, or to PodiatryCare, P.C. on my behalf, for all services rendered to me by the doctor. I authorize any holder of medical information about me to release to my insurance company and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services.

____**(Initials)** I hereby give permission to have my feet examined and treated. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay all expenses including reasonable attorney's fees, expenses, and court costs incurred in the collection of any sums due and owing for medical services provided. I will notify you of any change in my health status, or in any of the above information, which is true to the best of my knowledge.

____**(Initials)** I have received a copy of the Summary of Notice of Privacy Practices which PodiatryCare, P.C. follows as mandated by HIPAA (Health Insurance Portability and Accountability Act).

_____ _____

Patient (or representative) Signature **Date** **Doctor Signature** **Date**

PODIATRYCARE
Summary of Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information electronically;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices**.**
  A copy of the complete Notice is available upon request.