

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** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Relationship Self\_\_ Spouse\_\_ Child\_\_ Other\_\_

Patient Relationship Self\_\_ Spouse\_\_ Child\_\_ Other\_\_

**Reason for today's visit** \_\_\_\_\_

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

	Ach Yf	: UH Yf	G]ghYf	6 fch Yf	8 U [ \ hYf	Gcb
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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Insulin Dependent Y ___ N ___ | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gout                          | <input type="checkbox"/> Rheumatoid Disorder   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Stomach Ulcers        |
| <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Thyroid Disorder      |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> High Cholesterol              | <input type="checkbox"/> <b>Other</b> _____    |

       **NONE of the above conditions apply**

**Allergies** (check or note all that apply to you)

**Medications/vitamins/supplements with dosages**

       **NO KNOWN DRUG ALLERGIES**

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

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**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.**