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 May we leave a detailed message Y / N

Patients E-Mail _____ Local Pharmacy/Location_____

Emergency Contact_____ Phone _____ Relationship_____

Primary Care Physician _____City/Town_____

Who may we thank for referring you? _____

Primary Insurance_____

ID # _____ Group # _____

Subscriber Name_____ DOB _____

Subscriber Address _____

Relationship: Self__ Spouse__ Child__ Other__

Subscriber Employer _____

Secondary Insurance_____

ID# _____ Group # _____

Subscriber Name _____DOB _____

Subscriber Address _____

Relationship: Self__ Spouse__ Child__ Other__

Subscriber Employer _____

Reason for visit _____

Is this injury the result of a work related incident? ____Yes ____ No **MVA (Motor Vehicle Accident) ___ Yes ___ No**

Family Health History (past or present health problems) – Please check all that apply:

	Mother	Father	Sister	Brother	Daughter	Son
Autoimmune Disorder						
Bleeding Disorder						
Circulatory Problems						
Diabetes						
Heart Disease						
Neurological Disorders						
Stroke						

Name_____ Acct #_____

Height _____ **Weight** _____ **Shoe Size** _____

Please check if any of these are applicable to you:

___ Anemia	___ Dementia	___ High Blood Pressure	___ Parkinson's Disease
___ Arthritis	___ Depression	___ High Cholesterol	___ Raynaud's
___ Asthma	___ Diabetes Type 1	___ Kidney Disease	___ Rheumatoid Disorder
___ Autoimmune	___ Diabetes Type 2	___ Mental Health Disorder	___ Stomach Ulcers
___ Cancer	___ Fibromyalgia	___ Neurological Disorder	___ Thyroid Disease
___ Circulatory Disease	___ Gout	___ Neuropathy	
___ COPD	___ Heart Disease	___ Osteoporosis	

___ **NONE of the above conditions apply** ___ **Other**_____

Allergies/Sensitivities (check or note all that apply to you)

___ **NO KNOWN DRUG ALLERGIES**

___ Antibiotics _____
___ Aspirin
___ Betadine (Iodine)
___ Codeine
___ Ibuprofen (Advil, Motrin)
___ Latex
___ Local anesthetics (Lidocaine / Marcaine)
___ 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__ Other nicotine use? Y__N__

Do you utilize marijuana? Y ___ N ___ How Often? _____

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.