PATIENT REGISTRATION

A K S N

TODAY's DATE ______________

LAST NAME ______ First Name ______ M.I. ______ ☐ Male ☐ Female

By what name do you wish to be addressed ______ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address ______ City ______ State ______ ZIP ______

Primary Contact Phone ______
☐ Home ☐ Work
☐ Cell ☐ Other

Secondary Contact Phone ______
☐ Home ☐ Work
☐ Cell ☐ Other

E-Mail Address ______

Pharmacy Name and Phone Number ______

SS# ______ Birthdate ______ Age ______ Height ______ Weight ______ Shoe Size ______

Spouse's Name ______ Emergency Contact ______ Emer. Contact # ______

Name of Parent or Guardian if Patient is a Minor ______ Relationship to Patient ______

Parent/Guardian Contact # ______

INSURANCE INFORMATION

**Please present insurance card(s) to the receptionist

Primary Insurance Company Name ______ Group Number ______

Name of Policy Holder ______ Relationship to Patient ______

Name of Policy Holder's employer ______ Policy Holder's Date of Birth ______

Secondary Insurance Company Name ______ Group Number ______

Name of Policy Holder (if other than patient) ______ Relationship to Patient ______

Name of Policy Holder's employer ______ Policy Holder's Date of Birth ______

** We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit you insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.

REFERRAL INFORMATION

How did you find out about us?

☐ Family Member/Friend ☐ Phone Book/Yellow Pages ☐ Advertisement

☐ Dr. ______ ☐ Hospital ☐ Website

☐ Other ______ ☐ Building Sign

PODIATRIC HISTORY

Please indicate foot problems you now have or have had in the past

	Yes	No		Yes	No		Yes	No		Yes	No
Ankle Pain	☐	☐	Corn & Calluses	☐	☐	Foot or Leg Cramps	☐	☐	Planters Warts	☐	☐
Athlete's Foot	☐	☐	Cramps/Numbness in Feet or Legs	☐	☐	Heel Pain	☐	☐	Swelling in Ankles or Feet	☐	☐
Bunions	☐	☐	Flat Feet	☐	☐	Ingrown Toenails	☐	☐	Tired Feet	☐	☐

PATIENT REGISTRATION

REASON FOR VISIT

☐ Work Related ☐ Auto Accident ☐ Other Date of Injury ____________

Please describe the condition that brought you here ____________

____

How long have you had this condition? ____________

Which side of body do symptoms exist? ☐ Right ☐ Left ☐ Both

Type of Pain? ☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Sharp ☐ Shooting

Has pain gotten: ☐ Better ☐ Worse ☐ Stayed the Same

What aggravates the condition? ☐ Walking ☐ Running ☐ Standing ☐ Shoes

Have you had treatment on this condition before? ____________

Is yes, please provide details as to when and results. ____________

If work related, has your employer been informed? ______ Has a claimed been filed? ______ Claim #: ____________

MEDICAL HISTORY

Place a CIRCLE around item to indicate if you have any of the following or fill in appropriate blanks:

	Yes	No		Yes	No		Yes	No
Hearing loss	☐	☐	Family history of gout	☐	☐	Neuropathy, numbness	☐	☐
Eyes,Glaucoma__________	☐	☐	Family history of diabetes	☐	☐	Rheumatoid arthritis	☐	☐
Arthritis type____________	☐	☐	Gout	☐	☐	Skin disease, dermatitis,	☐	☐
Heart/ arrhythmias________	☐	☐	Migrane headaches	☐	☐	Sinusitis/seasonal allergies	☐	☐
Artificial Joints__________	☐	☐	Heart attacks/heart disease	☐	☐	Spinal cord injuries	☐	☐
Repiratory/Asthma,COPD	☐	☐	Dialysis,	☐	☐	GI-Reflux-GERD__________	☐	☐
Spinal/disk disease/herniation	☐	☐	Edema, lymphedema, statis	☐	☐	Stroke/TIA/CVA	☐	☐
Bleeding disorders/blood clots	☐	☐	High Blood Pressure	☐	☐	Osteoporosis/osteopenia	☐	☐
Cancer type____________	☐	☐	Kidney failure/stones	☐	☐	Neurologic/Sciatica/Alzheimers	☐	☐
Chemical Dependency	☐	☐	Prostate/ hypertrophy	☐	☐	Scoliosis,kyphosis, short limb	☐	☐
Paralysis, dropfoot, tremors	☐	☐	Liver Disease, hepatitis	☐	☐	Ulcers - Stomach, esophagitis	☐	☐
Depression/Anxiety	☐	☐	Current Pregnancy	☐	☐	GU-Urinary incontinence	☐	☐
Atherosclerosis/PVD/PAD	☐	☐	Hematalogic, anemia	☐	☐	Alcohol/ drug dependency	☐	☐
Diabetes Type I or II	☐	☐	Menopause	☐	☐	Inflamatory Bowel/Crohn's	☐	☐
Chemo/Radiation treatment	☐	☐	Neurosis/Pyschosis	☐	☐	Endocrine/hypothyroidism	☐	☐
Epilepsy, ADD, Dementia	☐	☐	Mental illness__________	☐	☐	____________		
Cataracts/lens replacement	☐	☐	Implants type__________	☐	☐	____________		

SURGERIES

Please list surgeries and when they took place

Surgery	Year	Surgery	Year

Hospitalization for other than mentioned above (please include pregnancy) ____________

____

____

____

____

PATIENT REGISTRATION

ALLERGIES

Please mark all that apply

No Known Allergies	☐	Codeine	☐	Local Anesthetics	☐	Seafoods	☐
Adhesive/Tapes	☐	Cortisone	☐	Metals/Jewelry	☐	Sulfa	☐
Anti-Inflammatory Meds	☐	Demerol	☐	Methiolate	☐	Other	☐ (Explain below)
Anticoagulant Therapy	☐	Iodine	☐	Novocain	☐		
Aspirin	☐	Latex	☐	Penicillin	☐		

MEDICATIONS

Please list all medications along with the reason or medical condition

SOCIAL HISTORY

Occupation ____________________ Employer ____________________

Cigarette/Tobacco Use ____________________ Years smoked/chewed __________

Alcohol servings per week __________

Athletic activities in which you participate (please list and indicate frequency)

GENERAL

Family Physician ____________________ Phone Number ____________________ Last Visit __________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

SIGNATURE ON FILE – PERMISSION TO TREAT

I request that payments of authorized benefits be made on my behalf for any services furnished me by **Sharp Podiatric Medicine and Surgery, LLC.** I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and noncovered services that may be required. I give permission to **Sharp Podiatric Medicine and Surgery, LLC,** to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Patient Signature ________________________________ Date: __________

PRIVACY STATEMENT

Sharp Podiatric Medicine and Surgery, LLC, will use and disclose your health information for the following purposes: to treat you, to assist other health care provider in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Patient Signature ________________________________ Date: __________

PATIENT REGISTRATION – FINANCIAL POLICY

WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding *preauthorizations, obtaining required referrals, second opinions, etc.*** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard, American Express, Discover). There will be a $25.00 charge for *returned checks. Delinquent accounts* will be referred for collection at the discretion of the office manager.

MANAGED CARE PATIENTS/PRIVATE INSURANCE: If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying any co-pays, coinsurance and deductibles required by your plan at the time of treatment.

MEDICARE PATIENTS: We accept assignment for Medicare; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $175.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. Sharp Podiatric Medicine and Surgery**,** LLC**,** has no part in billing for these supplies.

Please complete the following items:
What is your co-payment per visit: $________
What is your insurance annual deductible: $ __________ How much of the deductible is current (not yet paid): $__________
(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)
Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Patient Signature ______________________________ Date: ______________