Greater Orange Foot Care – Patient Registration and History

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ ZIP _____

Gender: ❑M ❑F Age _____ Date of Birth _____

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

Patient SS# _____

Patient Driver's License# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Spouse's Date of Birth _____ SS# _____

Spouse's Occupation _____

Spouse's Employer _____

How did you hear about our office? _____

2 PAYMENT ARRANGEMENTS

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Company or Self-pay _____

Subscriber Name _____

Subscriber's Date of Birth _____ SS# _____

ID# _____ Group# _____

Is patient covered by additional insurance? ❑Yes ❑No

Secondary Insurance Co. _____

Subscriber Name _____

Subscriber's Date of Birth _____ SS# _____

ID# _____ Group# _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above-mentioned insurance company and assign directly to Greater Orange Foot Care all insurance benefits, if any, otherwise payable for me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

✘ _____

Responsible Party Signature

_____ _____

Relationship to Patient Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf Greater Orange Foot Care (GOFC) for any services furnished me by the physicians at GOFC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

✘ _____

Beneficiary (Patient/Insured) Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home _____

Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 PODIATRIC HISTORY

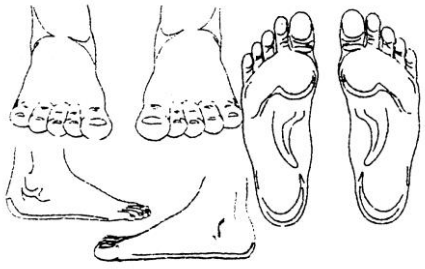
- What is the chief complaint for which you want to be treated? _____

- Describe Pain (if applicable):

❑ sharp/stabbing ❑ shooting ❑ grinding
❑ dull/achy ❑ radiating ❑ constant
❑ throbbing ❑ tingling ❑ burning
❑ comes & goes (how frequently?) _____

❑ other (please describe) _____

- Indicate where you are having these symptoms:



- How long have you had the symptoms?

- Did they begin suddenly or gradually?

- Have you tried anything that makes the condition better?

- What makes the condition worse?

- Have you tried any treatment for this condition?

- Have you been treated in the past for this condition? (if yes, when and by whom?)

- What is your goal for treatment?

– Over For More –

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	*Respiratory Disease*	❑ Yes	❑ No
Allergies to Anesthetics	❑ Yes	❑ No	*Eye Problems*	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Foot/Leg Cramps	❑ Yes	❑ No	*Shortness of Breath*	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	*Headaches*	❑ Yes	❑ No	*Stroke*	❑ Yes	❑ No
Artificial Heart Valves			*Heart Disease*	❑ Yes	❑ No	Swelling in Ankles/Feet	❑ Yes	❑ No
and/or Joints	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hepatitis/Jaundice	❑ Yes	❑ No	Thyroid	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No	*Ulcers*	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	*Liver Disease*	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	*Nervous Problems*	❑ Yes	❑ No	Weight Loss (unexplained)	❑ Yes	❑ No
Chronic Diarrhea	❑ Yes	❑ No	Phlebitis	❑ Yes	❑ No	Other(s):_____		
Circulatory Problems	❑ Yes	❑ No	*Psychiatric Care*	❑ Yes	❑ No	_____		
Diabetes	❑ Yes	❑ No	*Radiation Treatment*	❑ Yes	❑ No	_____		
Ear Problems	❑ Yes	❑ No	Rash	❑ Yes	❑ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last visit date _____

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

If yes, please explain _____

_____

_____

_____

6 MEDICATIONS

Please list prescriptions, over-the-counter medications, and vitamins/supplements you are currently taking _____

_____

_____

_____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ❑ Yes ❑ No

7 ALLERGIES

❑ Penicillin	❑ Sulfa
❑ Iodine	❑ Novocaine
❑ Aspirin	❑ Demerol
❑ Codeine	❑ Seafoods
❑ Adhesive/Tape	

❑ Other _____

_____

_____

_____

_____

8 CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature ✱ _____ Date _____