NEW PATIENT REGISTRATION FORM

Welcome to our office! Please complete the following:

Last Name _____ **First Name** _____ **MI** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Phone Number (____) _____ - _____ **Social Security #:** _____ - _____ - _____

Birth Date: ____ / ____ / _____ **Gender:** _____ **Marital Status:** _____

Email: _____

Employer: _____ **Work Phone** (____) _____ - _____

Occupation: _____

Person Responsible for Insurance/Account (if other than self): _____

Relationship: _____ **Birth Date (if other than self):** ____ / ____ / _____

Primary Insurance: _____ **Policy Number:** _____

Copay: _____ **Group Number:** _____

Secondary Insurance: _____ **Policy Number:** _____

Group Number: _____

Referred By (check one): □ **Website** □ **Google** □ **Facebook** □ **Insurance** □ **Friend** □ **Other**

□ **Doctor** _____ **Whom may we thank for referring you?** _____

Name of Primary Care Physician: _____ **Phone:** (____) _____ - _____

Date of Last Visit with Primary Care Physician: _____

Pharmacy: _____ **City:** _____ **Street:** _____

Emergency Contact: _____ **Phone:** (____) _____ - _____

AUTHORIZATION FOR SHARING OF PROTECTED HEALTH INFORMATION

Preferred contact phone number: (____) _____ - _____ **May we leave a detailed voicemail?** □YES □ NO

□ **The providers/staff of First Choice Podiatry may discuss my medical history/condition with the following:**

Name: _____ **Phone:** (____) _____ - _____ **Relationship:** _____

Name: _____ **Phone:** (____) _____ - _____ **Relationship:** _____

□ **I do NOT want my personal health information shared with anyone**

First Choice PODIATRY

MEDICAL HISTORY FORM

Patient Name: _____

Height: _____ Weight: _____ Shoe Size: _____

Have you ever received treatment from a previous podiatrist? _____

What is the reason for your visit today? _____

Any past foot/ankle surgery or problems? If yes, please list:_____

_____

PLEASE ANSWER THE FOLLOWING:

1. **Do you have AIDS, HIV, or Hepatitis?** □ YES □ NO
2. **Do you take a blood thinner or aspirin?** □ YES □ NO
3. **Females: are you pregnant?** □YES □ NO
4. **Smoker (Please Circle):** □ Everyday Smoker □ Former Smoker □ Non-Smoker
5. **Do you have diabetes?** □ YES □ NO **If yes:** □ TYPE I □ TYPE II **Controlled By:** □ Insulin □ Orals □ Diet
6. **Do you drink alcohol?** □ YES □ NO **If yes, how much (daily, weekly, monthly)?** _____
7. **Do you vape?** □ YES □ NO **Do you use illicit or recreational drugs?** _____

PAST MEDICAL HISTORY – Please check all that apply:

□AIDS/HIV □Anemia □Asthma □Arthritis □Artificial Joints/Implants □Back Problems □Bleeding Disorders □Cancer □Circulation Problems □Diabetes □Digestion Problems □Eye Problems □Gout □Heart Problems □High Blood Pressure □High Cholesterol □Kidney Problems □Leg Cramps □Liver Problems □Numbness □Seizures □Sickle Cell Trait/Disease □Stomach Ulcers □Stroke □Swelling in Ankles/Feet □Thyroid Disease □Tuberculosis

FAMILY HISTORY: Please list any medical history (diabetes, cancer, high blood pressure, etc)

Mother: _____ Father: _____

Sister: _____ Brother: _____

MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES:

Aspirin: □YES □ NO **Codeine:** □YES □ NO **Iodine:** □YES □ NO **Latex:** □YES □ NO **Local Anesthesia:** □YES □ NO
Sulfa: □YES □ NO **Penicillin:** □YES □ NO **Other: _____**

SURGICAL HISTORY:

_____ _____ _____

First Choice PODIATRY

FINANCIAL POLICY

PLEASE READ AND SIGN THE FOLLOWING FINANCIAL POLICY:

We will work with most insurance companies. **However, payments for services rendered are your responsibility**. If you have an HMO or POS plan requiring a referral, you must have a referral with you at that visit. You are responsible for co-pays, deductibles, and/or co-insurance under the terms of your insurance plan. All applicable co-payments, deductibles and co-insurance, and/or non-covered services are due at time of service. These amounts are estimates provided by your insurance company based on the insurance contract. Once the claims have been processed by your insurance company, there is a possibility that you may end up receiving a balance statement or a refund check.

You must notify the office of any insurance changes and authorization/referral requirements. In the event the office is not notified, you will be responsible for any charges denied.

There are no refunds or exchanges for supplies and/or medical equipment purchased in the office. All sales are final. Unfortunately, not every supply prescribed or recommended works for all patients. However, we strive to make every effort to have a satisfactory outcome.

There is a **$30 fee** for no-call/no-shows or appointment cancellations made less than 24 hours in advance.

I give First Choice Podiatry permission to treat me, request information from other physicians regarding my foot and ankle conditions and bill my insurance. Failure to pay bills promptly can result in legal actions to achieve collections. All collections and legal fees are the responsibility of the patient. A fee of 30% or greater may be addended to the bill if we are forced to take the account to collections. If you do not have insurance, payment in full is due on the day of service.

I have read and understand this form and all the information I provided is correct.

Signature: _____ Date: _____

Printed Name: _____

First Choice PODIATRY