



Patient Registration

PLEASE PRINT CLEARLY

Today's Date: \_\_\_\_\_

Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sex: M / F

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: M / D / S / W

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer/ School Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please tell us how you heard about us: \_\_\_\_\_ Referred by: \_\_\_\_\_

Insurance Information: (Please allow receptionist to photocopy your insurance cards and photo ID)

Primary Insurance Plan: \_\_\_\_\_ Policyholder Name \_\_\_\_\_

Policyholder SSN: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

Secondary Insurance Plan: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Policyholder SSN: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

Receipt of Notice of Privacy Practices

I attest that I have received a copy of the Advanced Foot & Ankle Center's Notice of Privacy Practices

Insurance Assignment and Release:

I certify that I have insurance coverage with the above listed company and authorize Advanced Foot & Ankle Center PC to submit claims to my insurance company for any services rendered to me. I assign all insurance benefits to be paid directly to Advanced Foot & Ankle Center PC. I understand that I am financially responsible for all charges whether or not paid by insurance.

Advanced Foot & Ankle Center PC may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will remain in effect for one year from the date signed below.

Medicare/Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Advanced Foot & Ankle Center PC for any services furnished to me by that provider. To the extent permitted by law, I authorize Advanced Foot & Ankle Center PC to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents, any information needed to determine these benefits or benefits for related services.

Treatment Consent:

I hereby consent and give permission to the physicians of Advanced Foot & Ankle Center PC to evaluate, administer, and perform such procedures upon me, as the doctor deems necessary.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# Medical History

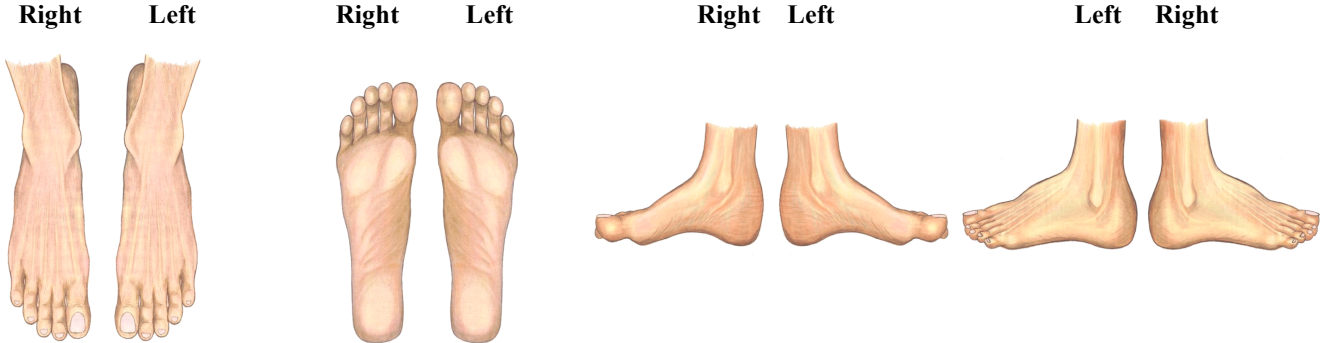
Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
 Date Last Seen by PCP: \_\_\_\_\_  
 Pharmacy Name/Location: \_\_\_\_\_

**Reason for Today's Visit:** *(please check all that apply)*

- Pain    Swelling    Numbness    Deformity    Other: \_\_\_\_\_

**Please circle the area of concern:**



How long have you had this problem: \_\_\_\_\_    Symptoms are:  Improving    Worsening    Unchanged  
 Describe your pain:  Sharp    Dull    Aching    Burning    Tingling    Other: \_\_\_\_\_  
 Symptoms are worse when:  Standing    Walking    Running    Other: \_\_\_\_\_  
 Symptoms are worse:  Morning    Evening    Night    All Day  
 Previous treatments include:  Rest    Elevation    Ice    Heat    Shoe Inserts    Injections    Brace/Bandage  
     Surgery    Medications    Other: \_\_\_\_\_  
 Have you been previously treated for this condition by another physician:    Yes    No

**Allergies:** *(please list)* \_\_\_\_\_

**Medications:** *(please list)*

Name of Medicine	Dosage	What is it for?

**Have you ever been treated for any of the following?** *(Please check below)*

- |                                    |                                      |                                  |                                      |                                  |  |
|------------------------------------|--------------------------------------|----------------------------------|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Heart       | <input type="checkbox"/> Stroke  | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Anemia  | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gout      | <input type="checkbox"/> Hemophilia  | <input type="checkbox"/> Asthma  | <input type="checkbox"/> Ulcers      | <input type="checkbox"/> Thyroid | <input type="checkbox"/> COPD                |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Stomach     | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nerves      | <input type="checkbox"/> Cancer  | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Liver     | <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Lupus   | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Tumors  | <input type="checkbox"/> Bleeding Disorder   |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Circulation | <input type="checkbox"/> Kidney  | <input type="checkbox"/> Bladder     | <input type="checkbox"/> HIV +   | <input type="checkbox"/> Mental Disease      |
| <input type="checkbox"/> RA        | <input type="checkbox"/> Pacemaker   |                                  |                                      |                                  |  |

**Social History:**

Height: \_\_\_\_\_    Weight: \_\_\_\_\_    Shoe Size: \_\_\_\_\_  
 Pregnant:  Yes    No    Claustrophobic:  Yes    No    Metal in Body:  Yes    No    Welder:  Yes    No  
 Do you drink Alcohol:  Yes    No    How much?: \_\_\_\_\_  
 Do you Smoke:    Yes    No    Packs per day?: \_\_\_\_\_    Former smoker    Everyday smoker    Never smoked

# Medical History

## Additional Medications:

Name of Medicine

Dosage

What is it for?

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## Surgeries/Hospitalizations: *(Please list)*

Type (circle one)

Year

Surgery Name or Reason for Hospitalization

Surgery / Hospitalization

Surgery / Hospitalization

Surgery / Hospitalization

Surgery / Hospitalization

**Injury:**  Yes  No *(If yes, please complete the following)*

Date of Injury: \_\_\_\_\_

How did injury occur?: *(Please be as detailed as possible)*

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## If Work Comp Related:

Employer Name: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Administrator Name: \_\_\_\_\_



## Advanced Foot & Ankle Center

Thank you for choosing us as your healthcare provider. We are committed to providing the best medical care possible to our patients. The following is a statement of our Financial Policy. We encourage you to discuss any questions you may have with our Billing Representative.

***PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.***

**REGARDING INSURANCE:** Every attempt will be made to verify your coverage. You are responsible for all co-payments, deductibles, procedures and supplies not covered by your insurance carrier. Your insurance policy is a contract between you and your insurance company; we are not part of that contract. If your insurance company has not paid your claim within 45 days we reserve the right to bill you for the balance.

**SURGERY DEPOSITS:** Prior to scheduling your surgery, our office will collect a \$50 deposit. This deposit will be applied to the surgery balance or refunded if your insurance pays in full. If you choose to cancel your surgery, you must cancel 1 week prior to your surgery date in order to receive a refund of this deposit. ***Prior to your surgery date, you will be required to pay all co-payments and/or deductibles.*** If you do not have insurance we will require 50% of the total due to be collected prior to surgery. All surgeries will be rescheduled if pre-payment is not made. We will provide you with an estimated billing amount that your procedure(s) may cost. This will be an **estimate only**.

**OUT OF NETWORK / SELF PAY:** Patients are responsible for payment in full at time of service, unless prior arrangements have been made with our Billing Representative.

**INSUFFICIENT FUNDS:** A \$25.00 fee for all returned checks will be charged to your account.

**REFUNDS:** Are issued after ***all*** claims have been paid and a credit balance is on the account.

**RELEASE AND ASSIGNMENT OF BENEFITS:** I hereby voluntarily request, authorize and consent to medical care including diagnostic treatments, as deemed appropriate by and delivered by Advanced Foot & Ankle Center, medical providers, related to the health problem(s) for which I have sought service. I further authorize Advanced Foot & Ankle Center to obtain and/or release medical records, x-rays, physical therapy, laboratory reports and other related information necessary to appropriately diagnose and/or treat my condition.

By signing below, I consent to the use or disclosure of my individual identifiable protected health information (PHI) by Advanced Foot & Ankle Center in order for them to treat me and receive payment for my treatment. I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information for Advanced Foot & Ankle Center.

**I agree and consent to all terms stated above by Advanced Foot & Ankle Center:**

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Signature of Patient, Guardian or Authorized Representative

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Date



**HIPAA**

**CONTACT/PICK-UP AUTHORIZATION**

Today's Date: \_\_\_\_\_

**CONTACT AUTHORIZATION**

I authorize Advanced Foot & Ankle Center PC's personnel to leave a detailed message on my voicemail/answering machine:

\_\_\_\_\_ YES

\_\_\_\_\_ NO

I authorize the following person to receive information regarding my healthcare and/or billing information:

Print First and Last Name of Person: \_\_\_\_\_

**PICK-UP AUTHORIZATION**

I authorize the person below to pick up prescriptions, DME supplies and forms on my behalf:

Print First and Last Name of Person: \_\_\_\_\_

**Note: Photo ID will be required**

Date: \_\_\_\_\_

Patient Name (*please print*): \_\_\_\_\_

Patient Signature: \_\_\_\_\_