PATIENT REGISTRATION & HISTORY

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- ☐ 301 Oxford Valley Rd., Suite 204, Yardley, PA 19067 • 215.493.8300
- ☐ 2808 N. 5th Street Hwy, Reading, PA 19605 • 610.921.8800
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PATIENT INFORMATION

Name ______________________________ Date ______________

Address ____

____

City ______________________ State ________ Zip ______________

Sex M F Single Married Separated Divorced

Age ____________ Birthdate ______________________________

Occupation ______________________ Patients SS# ______________

Employer ____

Employer's Address ______________________ Employer's Phone ____________

Spouse's Name ____________________ Birthdate __________ SS# __________

Occupation ______________________ Spouse's Employer ______________

Whom may we thank for referring you? ______________________________

CONTACT INFORMATION

Email ____

Phone Home ________________ Work ________________ ext. ________

Mobile ____

IN CASE OF EMERGENCY

Name ____________________ Relationship ____________ Phone ____________

INSURANCE

Who is responsible for this account? ________________ Relationship to Patient ____________

Insurance Company ______________________________________

ID# ______________________ Group# ______________________

Is Patient covered by additional insurance YES NO

Subscriber Name ____________________ Birthdate __________ SS# __________

Relationship to Patient ______________________________________

Insurance Co. ______________________________________

ID# ______________________ Group# ______________________

PATIENT REGISTRATION & HISTORY

MEDICAL HISTORY 1

What is the chief complaint today.

____

____

Have you ever been to a Foot Doctor before YES NO if YES - Name ____________ Last visit ____________

Do you presently smoke? YES NO if YES - Years smoked ____________

Have you previously smoked? YES NO I stopped ____________

Is there a family history of Diabetes YES NO

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________ and assigned directly to Dr. ____________ all insurance benefits, if any, otherwise payable to 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 ______________________________ Date ____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ____________ for any services furnished me by that physician. 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, mt signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ______________________________

PATIENT REGISTRATION & HISTORY

MEDICAL HISTORY 2 (check all that currently or previously apply to you):

- ☐ AIDS/HIV
- ☐ Allergies (specify)
- ☐ Allergies to Medicine or drugs
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ Cancer (specify)
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Diabetes - Type I or Type II (Circle)
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Fainting/Dizziness
- ☐ Foot or Leg Cramps
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis or Jaundice
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stroke / TIA
- ☐ Swelling in Ankles, Feet
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease
- ☐ Tired Feet
- ☐ Tuberculous
- ☐ Ulcers
- ☐ Varicose Veins Venereal Disease
- ☐ Weight Loss, unexplained

Please list any other medical conditions not list above ____________________

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 ____________________

Past Surgeries ____________________

____

Hospitalization (other than for surgeries listed) ____________________

MEDICATIONS (include prescriptions, over-the-counter and vitamins)

____

____

Pharmacy Name(s) ____________________ Phone# ____________________

____

Do you take oral contraceptives? YES NO

ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- Other ____________________

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's Signature Date