Initial Comprehensive Patient Registration

TODAY'S DATE______________________________________

PATIENT INFORMATION

PATIENT'S LAST NAME______________________________FIRST______________________________MIDDLE INITIAL__________
MAILING ADDRESS____APT NO________________________
CITY____STATE_____________________ZIP CODE_____________________
HOME PHONE ____CELL PHONE ____
PATIENT E-MAIL ADDRESS____
SEX: _____M_____F AGE________DATE OF BIRTH______________HEIGHT________WEIGHT________SHOE SIZE___________
SS#______________________________MARITAL STATUS: ______Single______Married______Widowed______Seperated______Divorced
OCCUPATION____EMPLOYER____
EMPLOYER ADDRESS____EMPLOYER PHONE_________________________________
SPOUSE'S NAME____
NAME OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR)____
PARENT/GUARDIAN SS#________________________________PARENT/GUARDIAN DATE OF BIRTH_________________________

REFERRAL INFORMATION – HOW DID YOU FIND OUT ABOUT US?

_______FAMILY MEMBER / FRIEND
_______NEWSPAPER
_______DR.__________________________
_______TV/RADIO AD
_______INSURANCE BOOK
_______HOSPITAL
_______PHONE BOOK/YELLOW PAGES
_______BUILDING SIGN
_______INTERNET/WEB SITE
_______OTHER_____________________________________

INSURANCE **PLEASE PRESENT YOUR INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST.

INSURANCE COMPANY NAME____GROUP NUMBER______________________
LAST NAME OF INSURED__________________________________FIRST NAME_________________MIDDLE INITIAL____________
RELATIONSHIP TO PATIENT____
INSURED'S SS#____INSURED'S DATE OF BIRTH______________________
INSURED'S EMPLOYER____ EMPLOYER PHONE #___________________________

REASON FOR VISIT What is the chief complaint for which you came to be treated?

____
Duration of Problem________________Have you had previous treatments? _ Yes _ No By Whom? __________________
Is this a work related injury? _ Yes _ No What is the date of the injury?____

How much pain do you have? (Please circle one)

1	2	3	4	5	6	7	8	9	10
No pain	Hurts a little		Hurts a little more		Hurt even more		Hurts a whole lot		Hurts worst

- **Frequency**: How often do you have your pain? (check one)
  - Constantly (100% of the time)
  - Occasionally (less than 30% of the time)
  - Intermittently (30-60% of the time)
  - Nearly constantly (60-95% of the time)

In general, during the past month, when has your pain/problem been the worst? (check one)
Morning   Afternoon   Early Evening   Night   No typical pattern

- **Symptom quality**: How would you describe your pain? (Check all that apply and circle the dominant quality)
  - Burning
  - Sharp
  - Cutting
  - Throbbing
  - Electric
  - Cramping
  - Dull/aching
  - Pressure-like
  - Shooting
  - Pins and needles
  - Walking on a pebble
  - Pain on first step of day
  - Other (describe) ____________________

- **Relieving and aggravating factors:** How does the following affect your pain? (circle one for each activity)

Activity			
Standing	**Decrease**	**No Change**	**Increase**
Sitting	**Decrease**	**No Change**	**Increase**
Waking	**Decrease**	**No Change**	**Increase**
Exercise	**Decrease**	**No Change**	**Increase**
Elevation	**Decrease**	**No Change**	**Increase**

Check all that apply.

Aggravated by: Weather ___ Shoe ___ Touch ___

Relieved by: Heat ___ Cold ___ Rest ___ Meds ___ Ace or compressive wrap ___

Activities and your pain:
How many blocks can you walk? Less than a block or How many blocks?_______

To assist walking, I use a: Cane Walker Wheelchair No assistance device

Are you **NOT** able to perform any of the following activities of daily living? (Circle all that apply)

Going to work Performing household chores Doing yard work or shopping

Wearing shoes Participating in recreational activities Exercising

Where did the injury occur?____

If the injury occurred at work, has your employer been notified? _ Yes _ No
Employer____Occupation____________________________
Address____
City_____________________________________State_____________________Zip Code___________________
Employer Phone #__________________________________Contact Person______________________________

MEDICAL HISTORY – Please indicate foot problems you now have or have had in the past.

Ankle Pain	_ Yes	_ No	Plantar's Warts	_ Yes	_ No
Heel Pain	_ Yes	_ No	Corns & Calluses	_ Yes	_ No
Athlete's Foot	_ Yes	_ No	Swelling in Ankle or Feet	_ Yes	_ No
Ingrown Toenails	_ Yes	_ No	Flat Feet	_ Yes	_ No
Bunions _ Yes _ No			Foot or Leg Cramps	_ Yes	_ No

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

Please list any surgeries:
Surgery____ Date_____________________________
Surgery____ Date_____________________________

Hospitalizations other than for surgeries listed____
____

Family Physician____Date of last visit_________________________
Address____Phone #_______________________________
Are you now, or have you been, under any other doctor's care for any reason over the past two years? _ Yes _ No

Substance abuse:

Have you ever been a smoker?	Yes-Current	Yes In-past	No-Never
If you smoke, how many packs per day?	_________ Packs per day		
For how many years did you smoke?	_________ Years		
Do you have a history of alcoholism?	Yes	No	Current problem
Have you abused prescription analgesics?	Yes	No	Current problem
Cocaine or intravenous substance abuse?	Yes	No	Current problem

How many years has it been since you abused alcohol or drugs? _______ Years

Review of Systems: Please circle yes or no if you have any of the following problems:

Ears/Nose/Throat/Mouth		
Hearing loss or ringing	Yes	No
Sinus Problems	Yes	No
Nose Bleeds	Yes	No
Sore throat/ voice change	Yes	No
Gastrointestinal		
Nausea/ vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/ asthma	Yes	No
Coughing up blood	Yes	No
Neurological		
Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/ seizures	Yes	No
Numbness/ tingling	Yes	No
Allergic/ Immunologic		
Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No
Hematologic/ Lymphatic		
Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
Genitourinary – Female Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Menstrual problems	Yes	No

Other

____
____
____

Constitutional		
Good general health	Yes	No
Recent Weight changes	Yes	No
Night sweats, Fevers	Yes	No
Fatigue	Yes	No
Eyes		
Wear glasses/ contacts	Yes	No
Blurred/ double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/feet	Yes	No
Musculoskeletal		
Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No
Integumetary (Skin/Breast)		
Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No
Endocrine		
Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No
Genitourinary – Male Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Testicle pain	Yes	No
Psychiatric		
Insomnia	Yes	No
Confusion/ Memory loss	Yes	No
Depression	Yes	No

MEDICATIONS – Include prescriptions, over-the-counter medications, and vitamins:

Medication____Dosage_________
Medication____Dosage_________
Medication____Dosage_________
Medication____Dosage_________

Do you take oral contraceptives? _ Yes _ No

Preferred Pharmacy Name____________________________Pharmacy Phone ________________________

ALLERGIES – Mark any that apply:

No Known Allergies _

Allergy		Allergy	
Adhesive Tape	_ Yes _ No	Cortisone	_ Yes _ No
Latex	_ Yes _ No	Sulfa Drugs	_ Yes _ No
Anti-Inflammatory Meds	_ Yes _ No	Demerol	_ Yes _ No
Local Anesthetics	_ Yes _ No	Eggs	_ Yes _ No
Anticoagulant Therapy	_ Yes _ No	Peanuts	_ Yes _ No
Novocain	_ Yes _ No	NSAIDS	_ Yes _ No
Aspirin	_ Yes _ No	Morphine	_ Yes _ No
Penicillin	_ Yes _ No	Ampicillin	_ Yes _ No
Codeine	_ Yes _ No	Glove Powder	_ Yes _ No
(Iodine) Seafood	_ Yes _ No	Other __________	

SIGNATURE & AUTHORIZATION TO PERFORM SERVICES

I request that payments of authorized benefits on my behalf for any services furnished me by Dynamic Foot Care, 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 coinsurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Dynamic Foot Care, 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.

Signed____Date_________________

FINANCIAL POLICY

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. **To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being perfomed.** We accept many different insurance plans, however all plans are not the same and do not cover the same services.

• 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. I neither 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.

• Uninsured Patients

A minimum payment of $125.00 in the form of cash or credit card is due at the time of service. Additional charges may apply.

• All Patients

For your convenience, we accept Visa, MasterCard, Discover, cash, or check. There is a $25 service fee for all returned checks.

Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Dynamic Foot Care, LLC

____ ________________________________
Patient or Authorized Representative's Initials Date

DURABLE MEDICAL EQUIPMENT POLICY

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Dynamic Foot Care, LLC. is **not** responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. ***Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.***

My initials below represent that I have read, understand, and accept this policy.

____ ________________________________
Patient or Authorized Representative's Initials Date

PRIVACY STATEMENT

Dynamic Foot Care, LLC will use and disclose your health information for the following purposes: to treat you, to assist other health care providers 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 operation 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.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY _ YES _ NO

SPOUSE ONLY _ YES _ NO

OTHER (PLEASE SPECIFY)_________________________________ _ YES _ NO

Acknowledgement of Receipt of Notice of Privacy Practices:
(Signature represents that I have been offered a copy of the policy)
I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the notice.

____ ________________________________
Patient or Authorized Representative's Initials Date