HAPPY FEET PODIATRY LLC - REGISTRATION AND HISTORY

-= Please Print =- Date:_____

1 PATIENT INFORMATION / DEMOGRAPHICS

Name_____ **Preferred Language:**_____

Gender: ☐M ☐F Age_____Birthdate_____ **Race:** *(check all that apply)*

Social Security # _____ African or African American ☐

Preferred Communication Method: Asian or Asian American ☐

Email ☐ Phone ☐ Mail ☐ Caucasian or European American ☐

Email_____ Hispanic or Hispanic American ☐

Home Phone_____ Native American or Native Alaskan ☐

Address_____ Native Hawaiian or Other Pacific Islander ☐

City/State/Zip_____ Other ☐

Cell Phone_____ **How did you find out about us?** _____

Work Phone_____ _____

2 PAYMENT / INSURANCE *(NOTE: All insurance will be verified before services provided)*

If '*No Insurance*' check here ☐ and sign below *[a deposit is collected before service]*

1st Insurance _____ 2nd **Insurance**_____

Coverage Holder_____ Coverage Holder_____

Relationship_____(*Name*)Birthdate_____ Relationship_____(*Name*)Birthdate_____

I, the undersigned certify that I (or my dependent) have coverage with the above mentioned insurance company(ies)(or paying cash) and assign directly to Happy Feet Podiatry LLC 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 (***Medicare Patients Only***)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the doctors of Happy Feet Podiatry LLC for any services furnished me by those physicians. 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 claims 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.

_____ _____
Medicare Beneficiary Signature Date

HAPPY FEET PODIATRY LLC – POLICIES AND CONSENT

Patient Name_____
Date:_____

3 NOTICE OF OFFICE POLICIES

- If you have medical insurance, you are required to present proof of insurance and photo identification prior to seeing the Doctor. You will be responsible for any charges not paid by your insurance company.

- If you do not have medical insurance, prior to service, we will provide a SELF PAY fee schedule showing our rates. Payment is due at the time of service.

- If your insurance company requires a referral, it must be available at the time of your visit. The office staff will not call your doctor for a referral. It is your responsibility to renew your referral if it expires. You will be responsible for any charges not paid by your insurance company.

- All copays and unpaid balances are required before you see the doctor. Checks should be made out to "Happy Feet Podiatry LLC".

I have reviewed the above information, and understand these policies are applicable to me as a patient of Happy Feet Podiatry LLC.

Patient/Authorized Signature_____ Date_____

4 ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient/Authorized Signature_____ Date_____

5 PHOTO CONSENT

I agree to allow Happy Feet Podiatry LLC to take pictures of my feet, lower leg and/or ankles. I also understand that these pictures may be used for any of the following purposes: historical reference, diagnostic, teaching, research, and/or presentations. I also understand that my face, name, and any other personal information will not be disclosed.

Patient/Authorized Signature_____ Date_____

6 CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of any medical conditions within the doctor's scope of practice.

Patient/Authorized Signature_____ Date_____

7 MEDICAL HISTORY Patient Name_____Date:_____

Reason for Today's Visit:_____

_____How long have you had this problem?_____

General Doctor_____ Phone_____

What is your activity level? _____

*Have you, or do you have? (**check all that apply**)*

General: □fatigue □nausea □chills □unexplained weight loss □**Women:** Are you pregnant?

Ears: □hearing loss □frequent ear infections □loss of balance

Eyes: □impaired vision □cataracts □glaucoma □macular degeneration

Nose: □sinus problems □allergies

Throat: □swollen glands □hoarseness □difficulty with speech

Respiratory: □asthma □bronchitis □emphysema □lung cancer

Cardiovascular: □hypertension □valve prolapse heart murmur □congestive heart failure □myocardial infarction heart attack

Vascular / Circulation: □blood clot deep vein thrombosis □leg pain at rest □atherosclerosis blocked arteries □circulation disorder

Gastrointestinal: □ulcer □hepatitis A □hepatitis B □hepatitis C □colitis □liver disorder □gallbladder problems

Sexually Transmitted: □gonorrhea □syphilis □Chlamydia □herpes □HIV

Genitourinary: □kidney stone □renal failure □renal dialysis □prostate problems □urinary tract infection (UTI) □Ovarian cancer

Hematological: □Anemia □sickle cell disease or trait □cancer/leukemia

Taking any blood thinners? □Coumadin (warfarin) □Heparin □Aspirin □Plavix □Other? _____

Endocrine: □diabetes □thyroid disease

Neurological: □seizures □stroke □tremor □cerebral palsy □multiple sclerosis □muscular dystrophy

Musculoskeletal: □arthritis □gout □rheumatoid arthritis □fibromyalgia □sciatica □back pain

Integument: □psoriasis □eczema □skin cancer □skin growth □thick scar keloid

7 MEDICAL HISTORY(continued)

Psychiatric: □depression □nervousness □anxious □phobias □bipolar disease
OCD
□suicidal □schizophrenia □psychoses

Social: □smoke tobacco □use marijuana □use cocaine □hallucinogenic drugs □recreational drugs

List recreational drugs:_____

Foot Surgeries: □**toenail** □**bunion** □**hammertoe** □**tendon repair** rerouting □**ankle** stabilization □**joint** fusion
□arthroscopy □fasciotomy

What is your shoe size and width:_____

Other surgical history: □pacemaker □angioplasty stent □heart valve repair replacement □appendectomy
□gallbladder □brain surgery □hysterectomy

Hospitalizations injuries or surgeries:_____

_____

Family History: □diabetes □cancer □hypertension high blood pressure □CVA / stroke □circulation problems

Other family history:_____

_____

8 MEDICATIONS

List all medications and dosage_____

_____

Pharmacy Name_____Address_____Phone_____

Do you take oral contraceptives? □ Yes □ No

9 ALLERGIES (*check all that apply*)

□ Adhesive Tape
□ Anticoagulant Therapy
□ Aspirin
□ Codeine
□ Demerol
□ Iodine
□ Local Anesthetics
□ Latex
□ Novocain
□ Penicillin
□ Seafood
□ Sulfa

Other_____

_____

10 LIFESTYLE (*please select one*)

□ 0 cigarettes per day (non-smoker or less than 100 in lifetime)
□ 0 cigarettes per day (previous smoker)
□ Few (1-3)cigarettes per day
□ Up to 1 pack per day
□ 1-2 packs per day
□ 2 or more packs per day
□ Other Tobacco User
□ Non Tobacco User
□ Do not wish to report

11 NOTES

_____

_____

_____