New Patient Registration Form

PATIENT INFORMATION

Patient's Name ____
First *Middle* *Last*

Date of Birth ______ / ______ / _______ Sex ☐ Male ☐ Female

Ethnicity/Race ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White ☐ Other

Address ________________________________ City _____________ State _____ Zip _______

Mobile Phone________________________________ Home Phone____________________________

Email (for appointment reminders) ____

Employer's Name ____

Emergency Contact ___________________ Relationship _____________ Phone ________________

How did you hear about us? ____
☐ Google ☐ Bing ☐ Yelp ☐ Insurance Website ☐ Other Internet Search

INSURANCE INFORMATION *(Please allow the receptionist to scan your insurance cards.)*

Primary Insurance ____

Policy # ______________________ Group # _____________________ Phone ________________

Secondary Insurance ____

Policy # ______________________ Group # _____________________ Phone ________________

INSURANCE POLICY HOLDER INFORMATION *(If the patient is the policy holder, you may skip this section.)*

Relationship of Patient to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Name ____
First *Middle* *Last*

Date of Birth ______ / ______ / _______ Sex ☐ Male ☐ Female

Address ________________________________ City _____________ State _____ Zip _______

Home Phone ______________________________ Mobile Phone ____________________________

Employer's Name ____

The above information is true to the best of my knowledge.

____ ____________________
Patient/Guardian Signature *Date*

Patient Health Form

Patient's Name ________________________________ Height __________ Weight __________

Primary Doctor's Name ________________________________ Date of Last Primary Visit______________

PRESENT CONDITION

What is your foot or ankle condition?____

____

How long have you had this? __________________________ What is your level of pain (0-10)? _______________

Have you tried any treatments?____

ALLERGIES ☐ No Known Drug Allergies

☐ Tape ☐ Codeine ☐ Cortisone ☐ Shellfish ☐ Latex

☐ Sulfa ☐ Penicillin ☐ Lidocaine/Anesthetics ☐ Other ______________________________

MEDICATIONS ☐ None

List prescriptions, over-the-counter medications, and vitamins ______________________________

____

____

HISTORY

Do you or anyone in your immediate family have any of the following conditions?

	Self	Family	None		Self	Family	None
Arthritis	☐	☐	☐	High Blood Pressure	☐	☐	☐
Bleeding Disorders	☐	☐	☐	High Cholesterol	☐	☐	☐
Blood Clots (DVT)	☐	☐	☐	HIV/AIDS	☐	☐	☐
Cancer ______________	☐	☐	☐	Kidney Disease	☐	☐	☐
Circulatory Disorders	☐	☐	☐	Liver Disease	☐	☐	☐
Coumadin Therapy	☐	☐	☐	Low Back Pain	☐	☐	☐
Diabetes Type __________	☐	☐	☐	Reflux (GERD)	☐	☐	☐
Dialysis	☐	☐	☐	Respiratory Disorders	☐	☐	☐
Glaucoma	☐	☐	☐	Sciatica	☐	☐	☐
Gout	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Disorders	☐	☐	☐
Hepatitis Type __________	☐	☐	☐	Other ____________	☐	☐	☐

Do you have numbness in your feet? ☐ Yes ☐ No Do you get leg cramps when you walk? ☐ Yes ☐ No

List previous surgeries with approximate dates ____

____

Do you smoke? ☐ Yes ☐ No ☐ Previously Packs per day _____ How many years have you smoked? _______

Do you drink alcohol? ☐ Yes ☐ No Number of drinks _______ per ☐ day ☐ week ☐ month

The above information is true to the best of my knowledge.

____ ______________________

Patient/Guardian Signature *Date*

Office and Financial Policies

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize direct payment of my insurance benefits to CarePlus Foot and Ankle Specialists or the physician individually for services rendered to my dependents or me by the physician or under his supervision. I understand that it is my responsibility to know my insurance benefits and whether the services I am to receive are a covered benefit. I understand and agree that I will be financially responsible for any copay or balance due that CarePlus Foot and Ankle Specialists is unable to collect from my insurance carrier for whatever reason.

MEDICARE AND INSURANCE BENEFITS
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to CarePlus Foot and Ankle Specialists or the physician on my behalf.

PAYMENT
Payment for foot care products and services including copays are due at the time of service. We accept cash, checks, debit, VISA, MasterCard, and American Express. There is a service fee of $40.00 for all returned checks. Failure to pay on accounts over 90 days may result in the account being turned over to collections and incurring additional fees.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION
I hereby authorize CarePlus Foot and Ankle Specialists or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL / CALL / TEXT / EMAIL
I certify that I understand the privacy risks of the mail, phone calls, text messages, and email. I hereby authorize a CarePlus Foot and Ankle Specialists representative or my physician to mail, call, text message, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying CarePlus Foot and Ankle Specialists to that effect in writing.

LAB / IMAGING STUDIES / DIAGNOSTIC SERVICES
I understand that I may receive a separate bill if my medical care includes lab, imaging studies, or other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

APPOINTMENTS
In fairness to our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24-hours notice may result in a fee of $40.00. You may be asked to pay before you are seen by the doctor. Patients who come to the office more than fifteen minutes later than scheduled may be asked to reschedule.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)
I understand that the HIPPA Notice of Privacy Practices is available at my physician's office and on the CarePlus Foot and Ankle Specialists website bellevuefootdoctor.com. I acknowledge that I have read (or had the opportunity to read) and understood the notice.

CONSENT TO TREATMENT
I hereby consent to evaluation, testing, and treatment as directed by my CarePlus Foot and Ankle Specialists physician.

____ ____________________
Patient/Guardian Signature *Date*