OHIO FOOT AND ANKLE CENTER PATIENT REGISTRATION

Patient Full Name:		Gender: ❑ Male ❑ Female	
Soc Sec #:	Date of Birth:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Preferred Phone: ❑Home ❑Cell ❑Work	Email Address:		
Marital Status: ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced			
Employer:	Employer Phone:	Occupation:	
Emergency Contact:	Relationship**:**	Phone #:	
Responsible Party (if other than self)			
Relationship to Patient ❑ Parent ❑ Spouse ❑ Other Please list -			
Address:	City:	State:	Zip:
DOB:	Soc Sec #	Primary Phone #:	

INSURANCE INFORMATION

Primary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:
Secondary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:
Tertiary Insurance Company:		
ID#:	Group#:	
Subscriber:	Soc Sec #:	DOB:
Worker Compensation Claim: ☐ **Yes** ☐ **No**	**Claim #:**	
If yes, Date Of Injury:	Physician of Record:	
Managed Care Organization:	Phone Number:	

I hereby give permission for Ohio Foot and Ankle Center to render the proposed Podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefits due to Ohio Foot and Ankle Center to be paid directly to Ohio Foot and Ankle Center.

I hereby give my permission for Ohio Foot and Ankle Center to forward any pertinent medical information to my primary or referring physician for continuity of care.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either me or my insurance company in writing.

The above information is true and I will notify Ohio Foot and Ankle Center of any changes.

Signature_____ Date_____

OHIO FOOT AND ANKLE CENTER PATIENT REGISTRATION

Primary Care Physician / Pharmacy / Personal Information

Primary Care Physician:			Phone#:
Date last seen:			
Height:	**Weight:**	**Shoe size:**	**Shoe width:**
Primary Pharmacy Name:			
Address:	City:	State:	Zip:
Phone #:			
Mail in Pharmacy Name:			
Address:	City:	State:	Zip:
Phone #:			

MEDICAL HISTORY

Do you have Diabetes: ❑ YES	**❑ NO**	**If yes, How long:**
How do you control your Diabetes:	❑DIET ❑INSULIN	❑ OTHER MEDICATION
What was your last Blood Sugar Level / or A1C:		

AIDS/ HIV	❑ Self ❑ Family	HEPATITS (A / B /C)	❑ Self ❑ Family
ANEMIA	❑ Self ❑ Family	HIGH BLOOD PRESSURE	❑ Self ❑ Family
ANXIETY	❑ Self ❑ Family	HIGH CHOLESTEROL	❑ Self ❑ Family
ARTHRITIS (GENERALIZED)	❑ Self ❑ Family	HYPERTENSION	❑ Self ❑ Family
ASTHMA	❑ Self ❑ Family	KIDNEY DISEASE	❑ Self ❑ Family
BLEEDING DISORDER	❑ Self ❑ Family	MENTAL DISEASE	❑ Self ❑ Family
BLOOD CLOTS	❑ Self ❑ Family	OSTEOPOROSIS	❑ Self ❑ Family
CANCER	❑ Self ❑ Family	POOR CIRCULATION	❑ Self ❑ Family
DEPRESSION	❑ Self ❑ Family	RHEUMATOID ARTHRITIS	❑ Self ❑ Family
EPILEPSY / SEIZURES	❑ Self ❑ Family	STD / STI	❑ Self ❑ Family
FIBROMYALGIA	❑ Self ❑ Family	STROKE	❑ Self ❑ Family
GOUT	❑ Self ❑ Family	THYROID / HIGH / LOW	❑ Self ❑ Family
HEADACHES	❑ Self ❑ Family	TUBERCULOSIS	❑ Self ❑ Family
HEARING PROBLEMS	❑ Self ❑ Family	VEIN DISORDER	❑ Self ❑ Family
HEART DISEASE	❑ Self ❑ Family	VISION PROBLEMS	❑ Self ❑ Family
PLEASE LIST OTHERS:			
HAVE YOU HAD ANY OF THE FOLLOWING PLEASE CIRCLE:	CHICKEN POX	MEASLES	MUMPS POLIO

FAMILY HISTORY:

NAME	LIVING / DECEASED	AGE	ADULT ILLNESS
MOTHER			
FATHER			

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No	Do you use drugs? ? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No		

OHIO FOOT AND ANKLE CENTER PATIENT REGISTRATION

HISTORY OF ANY SURGERIES / ACCIDENTS :

ALLERGIES / REACTIONS

PLEASE CIRCLE ALL THE APPLY

PLEASE ADD YOUR REACTION

NAME	REACTION	NAME	REACTION	NAME	REACTION
Aspirin		Nsaids		Penicillin	
Codeine		Demerol		Local Anesthetics	
Cortisone		Sulfa		Latex	
Iodine		Tape / Adhesives			
List Others					

CURRENT MEDICATION LIST

"IF YOU HAVE A MEDICATION LIST PLEASE GIVE TO THE FRONT DESK TO COPY"

NAME OF MEDICATION	USED FOR WHAT CONDITION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

CHIEF COMPLAINT:

When did the problem begin:
What treatments have you tried if any:
Have you seen another Doctor for this condition: ☐ Yes ☐ No
If yes, Who did you seek treatment from:
PAIN LEVEL 1-10 _____

PLEASE CHECK ALL THAT APPLY TO TODAY'S VISIT:

ACHING	BURNING	DEEP	DULL	ITCHING
NUMB	SUPERFICIAL	SHARP	SHOOTING	STABBING

OHIO FOOT AND ANKLE CENTER PATIENT REGISTRATION

PATIENT FINANCIAL RESPONSIBILITY FOR NO INSURNACE: If no insurance is to be filed by us, full payment is expected at the time of service.

CO-PAYMENTS: Are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: Only a parent, custodial parent in a divorce situation or guardian are able to authorize treatment. The parent, custodial parent or guardian is responsible for the full fee for services. We will not bill a second party. A copy of the custodial or guardianship agreement is requested for our records if applicable.

WORKERS' COMPENSATION: You must verify that your provider is approved to provide care under your employer's workers compensation plan. If applicable, Workers compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a separate workers' compensation form must be completed.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA, MasterCard and Discover Debit/credit card payments can also be accepted by phone.

NSF FEES: A fee of at least $30 but no less than the amount charged by the bank will be added to the patient's account per submission in cases of returned checks for non-sufficient funds (NSF).

PAST DUE ACCOUNTS: Outstanding balances after insurance payment will be invoiced to the responsible party on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice. In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including interest, collection fees, and reasonable attorney fees and court costs.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. After missed appointments, $40 maybe charged your account. We also reserve the right not to schedule you with our office any further, or you may be discharged from the practice entirely.

MISSED/ CANCELLED SURGERIES: We request a 48 hour notice to cancel all scheduled surgeries no matter the location of the surgery. If a 48 hours notice is not given a $50 charge may be applied to your account.

I DESIGNATE THE FOLLOWING PEOPLE MAY ACT ON MY BEHALF:

NAME:	**PHONE:**
NAME:	**PHONE:**
NAME:	**PHONE:**

FINANCIAL AGREEMENT: By signing this form, I, the patient, or the patient's representative, acknowledges that I have read, understood and received a copy of the Ohio Foot and Ankle Center Financial Policy. I understand and agree, regardless of my insurance status, that I am responsible for the balance of my account.

PATIENT'S PRINTED NAME	DATE

PATIENT OR RESPONSIBLE PARTY SIGNATURE	DATE