WM. TERRY HOLT, D.P.M.
NICOLAS ARCURI, D.P.M.

657 Skyline Drive
Jackson, TN 38301
(731) 427-5581

PATIENT PODIATRIC REGISTRATION AND HISTORY

(PLEASE PRINT)

PATIENT INFORMATION

Today's Date: _____

SS # _____

Last Name: _____

First Name: _____ **Middle** _____

Address: _____

City: _____

State: _____ **Zip:** _____

☐ **Male** ☐ **F** _____ **Race:** _____

Date of Birth: _____ **Age:** _____

Marital status: _____ or Minor

Student's school: _____

Employer: _____

Employer's Address: _____

Employer's Phone: _____

Whom may we thank for referring you? _____

PREFERRED METHOD OF CONTACT (Check Box)

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

E-Mail:_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Primary Insurance: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage listed above and assign directly to Drs. Holt & Arcuri 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 authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Beneficiary, Guardian, or Personal Representative

_____
Print name of Beneficiary, Guardian, or Personal Representative

_____
Date Relationship to Beneficiary

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare, and Medigap if any, benefits be made to Drs. Holt & Arcuri on my behalf for any services provided to me by this practice. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the CMMS, my Medigap insurer or their agents any information needed to determine the benefits for related services.

_____
Signature of Beneficiary, Guardian, or Personal Representative

_____
Print name of Beneficiary, Guardian, or Personal Representative

_____
Date Relationship to Beneficiary

***** RECENT HIPPA LAWS REQUIRE THAT WE ASK THE FOLLOWING: *****

Should medical records need to be released, who may we release these records to?

☐ Another doctor's office ☐ Employer ☐ Other: _____ ☐ **Any of the above**

Note: If not indicated, then patient must come by the office and sign a release before records can be sent.

May a family member (spouse/child/etc.) pick up these records if patient is unable to come by the office? ☐ YES ☐ NO

We have your permission to contact you to provide appointment reminders. Messages may be left with the person answering the telephone, answering machine, voicemail, or email; if you are not available.

Signature: _____ **Date:** _____

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(PLEASE PRINT)

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____
_____
_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list below:

Name of Doctor _____

Last visit _____

Is there any personal of family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

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

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle pain	☐ Yes ☐ No
Athletes foot	☐ Yes ☐ No
Bunions	☐ Yes ☐ No
Corns and calluses	☐ Yes ☐ No
Cramps or numbness in feet	☐ Yes ☐ No
Flat feet	☐ Yes ☐ No
Foot cramps	☐ Yes ☐ No
Heel pain	☐ Yes ☐ No
Ingrown toenails	☐ Yes ☐ No
Plantar warts	☐ Yes ☐ No
Swelling in ankles or feet	☐ Yes ☐ No
Tired feet	☐ Yes ☐ No

MEDICAL HISTORY

AIDS/HIV	☐ Yes ☐ No	Eye problems	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Foot or leg cramps	☐ Yes ☐ No	Respiratory disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Artificial heart valves or joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Back problems	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Special diet	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Hepatitis / Jaundice	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer(type)_____	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Swelling in ankles, feet	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	Hysterectomy	☐ Yes ☐ No	Swollen neck glands	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No	Tired feet	☐ Yes ☐ No
Chronic diarrhea	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Varicose veins	☐ Yes ☐ No
Ear problems	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No	Weight loss, unexplained	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No		

Surgeries you have had _____

_____

Hospitalization other than for the surgeries listed above _____

Primary care physician (PCP) _____ **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 _____

MEDICATIONS

(Include prescriptions, over-the-counter medications and vitamins)

_____

_____

_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive / Tape	☐ Local anesthetics
☐ Anticoagulant therapy	☐ Novacaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafood
☐ Demerol	☐ Sulfa
☐ Iodine	☐ Other _____

PHARMACY name(s) and phone(s) _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to patient

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Notice of Privacy Practices and Financial Policy

We keep a record of the health care services we provide you. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This may include your health insurance plan if it requires information before it approves or pays for the health care services recommended for you. You may get more information by contacting our staff or Privacy Officer.

1) SIGNATURE_____
****

AUTHORIZATION TO SHARE HEALTHCARE INFORMATION
I permit you to share my healthcare information with (NAME)_____
Or FAX #_____ (Relationship)_____
This authorization ends only upon my written request

2) SIGNATURE_____
****

Our office realizes that understanding our financial policies is an essential element of our patient healthcare and treatment. If you have any questions, please discuss them with our front office staff or business manager.

You are responsible for all prior authorizations/referrals needed to seek treatment in this office. The doctor may recommend services he feels are beneficial but may not be covered by insurance; and it is your responsibility to understand the limit and restrictions affecting coverage for these services. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. In the event you do not inform the office of insurance changes, you will be responsible for any charges denied. Your insurance policy reimbursement is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all copays, deductibles, co-insurance amounts, along with the entire amount of any non-covered services. Payment for services is expected at the time of service, unless other arrangements have been made in advance with our business office. We will accept VISA, MasterCard, Discover, cash or check. There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee. We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery. For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees are your responsibility in addition to the balance due our office.

3) SIGNATURE_____

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Thank you for scheduling an appointment with us. In order to provide a convenient check in when you arrive at our office, please bring the following:

- Driver's license or identification
- Insurance card(s) and co-pay or deductible (if required)
- List of current medications and allergies
- Referral from Primary Care Physician (if needed)
- Comfortable enclosed shoes (tennis shoes, loafers, boots)
- New patient form completed (may print from website www.drterryholt.com)