PATIENT REGISTRATION FORM

Patient: _____ Date of Birth _____ Sex: M F
First Middle Last

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone_____Soc Sec #_____

Occupation: _____

Responsible Party (If under 18 years of age)_____

Email address: _____

Ethnicity:	**Race:**	**Preferred Language:**
Hispanic	Black or African American	English
Latino	Native Hawaiian/other Pacific Islander	Spanish
Neither	Asian	
	White	
	Patient Declined	

Primary Care Doctor: _____

Referred to us by:_____

Emergency Contact Person_____phone:_____

Insurance Information

#1 Insurance Name _____

Address _____

_____

ID#_____

_____
Name of Insured **DOB**

#2 Insurance Name _____

Address:_____

_____

ID#_____

_____
Name of Insured **DOB**

The responsible party agrees to the following for the above listed individual(s): (Must be 18 years or older to provide signature)

1. Assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private Insurance, and other health plan to physician rendering service.
2. Grant permission to the physician to perform any medical treatment necessary
3. Pay the doctor at the time treatment or service is received or by previous arrangements (insurance)
4. Pay for all legal fees and reasonable costs incurred in connection with debt collection.
5. Authorize my insurance benefits to be paid directly to the doctor.
6. Pay any balance that my insurance company does not cover.
7. Authorize the doctor or insurance company to release any information required for claims regarding the above listed individuals.

X Signed:_____ Date:_____

Mountain View Foot and Ankle Institute
David B. Glover, DPM, FACFAS

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

Patient Name_____ Age_____ F__ M__

Medical Problems: None ( ) _____

_____

Prior Surgeries or Hospitalizations (within past 2 years): None ( )_____

_____

Current Medications and dosages: None ( ) _____

_____

Major Allergies _____ Minor Allergies_____None ( )

Alcohol Use: Y N Tobacco use: Y N packs per day for _____ years

Weight_____ Height_____ Are you claustrophobic? Y N

Circle if you have recently had any of the following symptoms:

Weight loss	Eye Problem	Asthma
Abdominal pain	Deafness	Pneumonia
Fever	Mood Changes	Fractures
Diarrhea	Ringing in the ears	Cough
Latex allergy	Seizures	Arthritis
Constipation	Dizziness	Coughing up blood
Eczema	Weakness	Joint Swelling
Urinary Problems	Chest pain	Bleeding tendency
Skin or hair changes	Wasting of muscles	Masses, scars, rashes
Incontinence or urine	High blood pressure	Anemia
Double vision	Balance problems	Pregnancy
Depression	Irregular heart beat	Cancer
	Memory loss	

Family History (Mother, Father, Bro, Sis,Paternal Gparents, Maternal Gparent) PLEASE SPECIFY:

Diabetes_____ Arthritis_____
Heart Disease_____ Cancer_(type of)_____
Strokes_____

Briefly describe reason for being seen today and/or accident details:

_____

_____

RELEASE OF INFORMATION

I understand that

1. My records are protected and cannot be disclosed without written permission.
2. Once this facility discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
3. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 (164.524).
4. This authorization will remain in effect for one year or I provide a written notice of revocation to this facility.

Signed:_____ Date_____