PATIENT REGISTRATION FORM

Today's Date: _____ Referred By: _____

Patient First Name: _____ MI_____ Last Name: _____

Sex: M F Race: (circle one) White Black Hispanic Other: _____

Birth Date: _____ Marital Status: (circle one) Single Married Divorced Widowed

S.S. #_____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Patient Employer: _____ Patient Occupation: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip: _____

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____

Insurance Company_____ Facebook_____ Other_____

FINANCIALLY RESPONSIBLE PARTY

Note: If patient is under 18 years of age this information is regarding the parent/legal guardian with the patient today

First Name: _____ MI _____ Last Name: _____

Sex: M F Birth Date:_____ Age: _____

Address: _____ SS #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone Number: _____

INSURANCE POLICY HOLDER INFORMATION

Note: This information is regarding the person who carries the insurance

Full Name: _____ Date of Birth: _____

Address: _____ S.S. # _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____

Employer Name: _____ Employer Phone _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Comprehensive History Form

Name: _____ **Family Physician:** _____

Family Physician Phone: ( )_____ Date Last Seen: _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Past Medical History:

Ulcers	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Cancer:_____	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No
Night Sweats	❑ Yes	❑ No
Persistent Cough	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No

Other _____

Medications: (List Dose and How Often Taken)
(If you have a current list we will copy it)

1 _____
Dose _____
2 _____
Dose _____
3 _____
Dose _____
4 _____
Dose _____
5 _____
Dose _____
6 _____
Dose _____
7 _____
Dose _____

Previous Surgery (s): You may use back of form if necessary

_____

_____

Allergies: _____

Family History:
Does Anyone in Your Family Have a History of any of the following:

			Family Member
High Blood Pressure	❑ Yes	❑ No	_____
Diabetes	❑ Yes	❑ No	_____
Heart Disease	❑ Yes	❑ No	_____
Stroke	❑ Yes	❑ No	_____
Cancer	❑ Yes	❑ No	_____
Thyroid Disease	❑ Yes	❑ No	_____

Is your father: Living or Deceased Cause of Death _____
Is your mother: Living or Deceased Cause of Death _____

Social History:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Do you live alone? ❑ Yes ❑ No

Occupation: _____

Do you smoke? ❑ Yes ❑ No ❑ Former If yes, how much per day _____ How many years? _____

Do you drink alcohol? ❑ Never ❑ Daily ❑ Occasionally ❑ Rarely

Do you exercise? ❑ Never ❑ Rarely ❑ Regularly

Patient Signature: _____ Date: _____

North Central Indiana Podiatry, LLC.

LIFETIME AUTHORIZATION

Insurance assignments and Authorization to Release Information

1) **RELEASE OF INFORMATION** – I, the below named patient, do hereby authorize the physicians of North Central Indiana Podiatry, LLC, to release to my insurance company any medical records concerning my diagnosis and treatment, when requested by the insurance company, for its use in connection with determining payment on a claim.

2) **PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named subscriber, hereby authorize payment directly to the physicians of North Central Indiana Podiatry, LLC, from my insurance company for services rendered.

3) **MEDICARE/MEDICAID** – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under the Title XVIH/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family services or its intermediaries or carriers, any information needed for processing of related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

4) **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE**. *This assignment will remain in effect until revoked by me in writing.*

****Please remember that your insurance benefits are a contract between you and your insurance carrier. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges billed. I understand it is my responsibility to pay any **DEDUCTIBLE AMOUNT, CO-INSURANCE, COPAYS, OR ANY OTHER BALANCE NOT PAID FOR** by my insurance or third payer within a reasonable period of time.****

If this account is assigned to an attorney for collection and/or suit you shall pay reasonable attorney's fees and costs of collection.

5) I have seen and read a copy of the Notice of Privacy Practices.

6) **CONSENT TO TREAT** – I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies that are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient Name, PRINTED: _____

Patient Signature: _____ Date _____

(If patient is under 18, legal Guardian must sign)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance and Accountability Act of 1996) law allows for the use of the information for treatments, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
* The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or sent text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the member allowed:

NAME RELATIONSHIP

_____

_____

This consent was signed by:_____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness:_____ Date:_____