

Patient Registration

Date: ____ / ____ / ____

NAME: Last _____ First _____ Initial _____

Social Security #: _____ - _____ - _____ Age: _____ Date of Birth: ____ / ____ / ____ Sex: M F

Referred by: Doctor Family Friend Internet Yellow Pages Other _____

Personal Physician: _____ Date last seen: ____ / ____ / ____

Home Address: _____ City: _____ Zip: _____

Phone: _____ Spouse/Next of Kin: _____ Phone: _____

Emergency contact name: _____ Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Name and Address

Party responsible for account: _____ Address (if different): _____

Subscriber's full name: _____ Date of Birth: ____ / ____ / ____

Insurance Company: 1) _____ 2) _____

Group #: 1) _____ 2) _____ Policy #: 1) _____ 2) _____

I hereby give my permission to Dr. Aufderheide or Dr. Yung to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of responsible party: _____ Date: ____ / ____ / ____

Insurance

Patient Registration

NAME: Last _____ First _____ Initial _____

MAJOR DISEASE

- Diabetes
- High blood pressure
- Angina
- Heart disease
- Kidney problems
- Heart attack
- Bladder problems
- Arrhythmia
- Heart murmur
- Mitral valve prolapse
- Stroke
- Chest pain
- HIV/AIDS

HEAD/EYES/EAR/NOSE/THROAT

- Headaches
- Eye problems

RESPIRATORY

- Asthma
- Bronchitis
- Frequent colds
- Lung disease
- Shortness of breath

ARTHRITIS

- Osteoarthritis
- Rheumatoid
- Gout

VASCULAR

- Anemia
- Sickle cell
- Bleeding disorders
- Poor Circulation
- Night cramps
- Leg pain when walking
- Vein problems
- Spider veins
- Varicose veins
- Swelling phlebitis
- Leg ulcerations
- Emphysema

GASTROINTESTINAL

- Ulcers
- Bowel disorders
- GI or rectal bleeding
- Acid reflux (GERD)

MISCELLANEOUS

- Epilepsy
- Thyroid disease
- Muscle disease
- Prostate problems
- Venereal disease
- Skin conditions
- Cancer history
- Hepatitis
- Hearing problems

PSYCHOLOGICAL

- Anxiety
- Depression
- Psychiatric conditions
- Drug dependence

OTHER

- _____
- Single Married
- Tobacco: ___ packs/day for ___ years
- Alcohol: ___ oz/day

ALLERGIES: Penicillin Sulfa drugs Aspirin Codeine Iodine/Shellfish Tape Latex

Local anesthetics General anesthetics Other: _____

MEDICATIONS: Antibiotic Aspirin Blood pressure Insulin Lipid-lowering Anti-depressant

Other: _____

HERBS: Echinacea Garlic Ginger Ginkgo Biloba St. John's Wort Ginseng

Kava Kava Feverfew Ephedra Other: _____

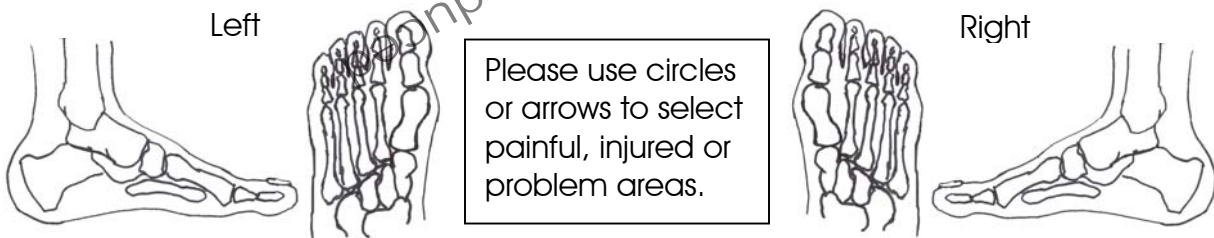
Current foot problem: _____ When did it begin? _____

What makes it worse? _____

What makes it better? _____

Previous treatment by whom/where? _____

Your height: ___ft ___in Your weight: ___lbs (This information is needed to make custom orthotics.)



Medical and Social History

Foot Pain

Patient Registration

NAME: Last _____ First _____ Initial _____

Explanation and Acknowledgement Regarding Privacy Practices

My signature below confirms that I have been informed of my right to privacy regarding my protected health information, under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used in the following manner:

- To provide and coordinate my treatment among a number of health care providers who may be involved in that treatment, either directly or indirectly.
- To obtain payment from third party payers for my health care treatment services.
- To conduct normal health care operations such as quality assessment and improvement activities.

I have been informed that my podiatric provider's complete Notice of Privacy Practices document contains further description of the uses and disclosure of my protected health information and that I have the right to review and receive a copy of the document. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy.

I understand that I may request, in writing, that this office restrict how my private information is used or disclosed in the course of carrying out my treatment, obtaining payment for my treatment, or in the course of this office's health care operations. I understand that this office is not required to agree to my requested restrictions, but if such an agreement is in place that this office is bound to abide by such restrictions.

Signature: _____ Date: ____/____/____

Relationship to patient: _____

Dependent family members covered by this acknowledgement: _____

FOR OFFICE USE ONLY: Patient's written acknowledgement of this document was not obtained because:

patient refused to sign communication barrier emergency situation other: _____