PODIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date ______________________

Patient Name ______________________________

Address ______________________________

____

City State Zip

Sex: ☐ M ☐ F Age _____ Birth Date __________

Patient SS# ______________________________

Occupation/Employer ______________________

Employer ______________________________

Work Address ______________________________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name ______________________________

Birth Date ______________ SS# ______________

Occupation/Employer ______________________

Did another physician refer you to our office?

☐ Yes ☐ No, Their name ______________________

Whom referred you? ______________________

Who is your Primary Care Dr:

PHONE NUMBERS

Home _______________ Cell _______________

Work______________________________

Best time & place to reach you ______________

IN CASE OF EMERGENCY, CONTACT

Name _______________ Relationship __________

Home phone ____________ Work ____________

INSURANCE

Who is responsible for this account? ______________________

Relationship to patient ______________________________

Insurance Co. ______________________________

Policy # ________________ Group # ________________

Supplemental Insurance Company ______________________

Subscriber Name ______________________________

Birth Date ________________ SS# ________________

Relationship to patient ______________________________

Policy Dates From ______________ to ______________

Policy # ________________Group # ________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. Steve Tillett 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________

Responsible Party Signature Date

______________________________ ______________

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steve Tillett for any services furnished me by that physician. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________

Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

____

____

____

____

____

Have you ever been seen by a Foot Specialist before? ☐ Yes ☐ No

If yes, please list:

Name ______________________________

Last visit ______________________________

Shoe Size ____________

Weight ____________

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

____

____

____

____

____

Is there a personal or family history of Diabetes? ☐ Yes ☐ No

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

Heel pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No