Patient Registration Form

Date of Appointment

Patient Information

First Name

Middle Name / MI

Last Name

Sex

Marital Status

Date of Birth

Social Security Number

Patient Address Line 1

Patient Address Line 2

City

State *

Zip

Home Phone

Cell Phone

Email

Referred by

Primary Care Physician

Primary Care Physician Phone

Pharmacy

Pharmacy Phone

Pharmacy Address

Patient Employer/School Information

Employer Name

Professional Title

Employer Phone

Employer Address Line 1

Employer Address Line 2

Employer City

Employer State

Employer Zip

School Name

School Phone

School Address

City

State

Zip

Emergency Contact Information

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

Billing and Insurance

Primary Health Insurance

Primary Insurance Name

Primary Plan Name

Primary Subscriber ID

Primary Group No.

Insured's Employer/School

Insured's Name

Primary Relationship to Insured

Insured's Phone Number

Insured's Address

City

State

Zip

Insured's Social Security Number

Insured's Birthdate

Secondary Health Insurance

Secondary Insurance Name

Secondary Plan Name

Secondary Subscriber ID

Secondary Group No.

Insured's Employer/School

Insured's Name

Secondary Relationship to Insured

Insured's Phone Number

Insured's Address

City

State

Zip

Insured's Social Security Number

Insured's Birthdate

Responsible Party

Billing Name

Phone

Relation to Patient

Address

City

State

Zip

Signature of Patient or Authorized Guardian

Date

____

Past Medical History

Have you ever had any of the following?

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] AIDS/HIV
- [ ] Back Problems
- [ ] Bleeding Disorder
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Diabetes
- [ ] Depression
- [ ] Ear Problems
- [ ] Eating Disorder
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart Disease
- [ ] Heart Problems
- [ ] Hepatitis - A, B, or C
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Joint Disorder
- [ ] Kidney Disorder
- [ ] Liver Disorder
- [ ] Lung Disease
- [ ] Measles
- [ ] Migraines
- [ ] Osteoporosis
- [ ] Pneumonia
- [ ] Polio
- [ ] Rheumatic Fever
- [ ] Stroke
- [ ] Skin Disorder
- [ ] Stomach Ulcer
- [ ] Substance Abuse
- [ ] Thyroid Disorder
- [ ] Tuberculosis
- [ ] Venereal Disease

Family History

Has anyone in your family ever had any of the following conditions?

- [ ] Alcoholism
- [ ] Allergies
- [ ] Alzheimer's
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] AIDS/HIV
- [ ] Bleeding Disorder
- [ ] Blood Disorder
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Genetic Disorder
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] Joint Disorder
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Migraines
- [ ] Psychiatric Disorders
- [ ] Osteoporosis
- [ ] Stroke
- [ ] Substance Abuse
- [ ] Thyroid Disorder

Details

____

Women Only

Are you pregnant?

○ Yes ○ No

Are you breastfeeding?

○ Yes ○ No

Reason for Visit

What brings you to the office today?

____

Please describe any previous treatment and care you have received for this problem.

____

Pain Assessment

Indicate your level of pain on a scale of 1 - 10 (10 = worst pain imaginable)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Check the symptoms that best describe your problem.

☐ Stiffness ☐ Pain ☐ Instability ☐ Swelling ☐ Numbness ☐ Other

If Other, specify

____

Are your symptoms getting...

○ Better Gradually ○ Better Rapidly ○ Worse Gradually ○ Worse Rapidly

What improves your symptoms?

☐ Rest ☐ Ice ☐ Heat ☐ Motrin/Aleve ☐ Other

If Other, specify

____

What makes your symptoms worse?

☐ Activity ☐ Cold ☐ Other

If Other, specify

____

Podiatry

Do you have any of the following?

- [ ] Ankle Sprain
- [ ] Arch Pain
- [ ] Athlete's Foot
- [ ] Broken Ankle
- [ ] Broken Foot Bones
- [ ] Bunions
- [ ] Burning in Feet
- [ ] Corns/Calluses
- [ ] Cramps in Feet
- [ ] Cramps in Legs
- [ ] Enlarged Veins
- [ ] Flat Feet
- [ ] Foot Numbness
- [ ] Foot Ulcers
- [ ] Fungal Nails
- [ ] High Arch Feet
- [ ] Heel Pain
- [ ] Hammer Toes
- [ ] Ingrown Nails
- [ ] In-toeing
- [ ] Knee Pain
- [ ] Leg Ulcers
- [ ] Loss of Sensation in Feet
- [ ] Lower Back Pain
- [ ] Rash on Feet
- [ ] Swelling in Ankles
- [ ] Swelling in Feet
- [ ] Swelling in Legs
- [ ] Tingling in Feet

Do you currently or have you ever worn orthotics?
○ Yes ○ No

Does your foot pain limit your desired activity?
○ Yes ○ No

Are your first steps out of bed in the morning painful?
○ Yes ○ No

Have you ever had any other foot problems?
○ Yes ○ No

If so, please describe

____

Lifestyle Factors

Patient Smoking Status ______

# of years ______

Patient Smoking Frequency ______

Do you use recreational drugs?
○ Yes ○ No

Types? ______

 # times/week ______

How much alcohol do you drink per week? ______

How much caffeine do you drink per day? ______

How often do you exercise? ______

How many hours a day do you stand? ______

What type of shoes do you wear?
☐ Flat ☐ Heels ☐ Boots ☐ Loafers ☐ Oxfords ☐ Sandals ☐ Sneakers ☐ Other

If Other, specify ______

Hospitalizations & Surgeries

Reason	Date	Reason	Date

Current Medications

Are you currently taking any blood thinners?

- [ ] Yes
- [ ] No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- [ ] Adhesive Tape
- [ ] Barbiturates (Sleeping Pills)
- [ ] Codeine
- [ ] Antibiotics
- [ ] Aspirin
- [ ] Sulfa
- [ ] Latex
- [ ] Iodine
- [ ] Local Anesthetics

Do you have any other allergies?

Name	Reaction	Name	Reaction

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 patient's 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 Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of 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 for, 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 disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a 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 members allowed:

____

This consent was signed by:

____

Signature

Date

____

PROGRESSIVE PODIATRY & FOOT SURGERY
19 WEST 34TH STREET SUITE 608
NEW YORK, NY 10001
212-244-7670

Authorization for Use of Signature On File for Claim Authorization

Social Security Number ____________ First Name ____________ Middle Name / MI ____________ Last Name ____________

I, ____________ authorize ____________

Mark the section "ENROLLE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".

This section authorizes:

1. The release of any medical information necessary to process this claim.
2. Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in force until terminated in writing by the enrollee.

Enrollee Signature

Date

____

Agreement for Doctor to Receive Insurance Checks

I, the undersigned, realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

Patient Signature

Date

____