

Patient Registration Form

Personal Information

Today's date: _____

Patient's First Name: _____ MI: _____ Last Name: _____
Date of Birth: ____/____/____ Gender: Male / Female / Other
Social Security #: _____ - _____ - _____ Marital Status: Married / Single / Divorced / Widowed
Race: White / Asian / African American / Hispanic / Latino / Pacific Islander / Native American
Ethnicity: Hispanic or Latino / Non-Hispanic or Latino
What is your preferred language? English / Spanish / Mandarin / Italian / Other: _____
Home Address: _____ City: _____ State: _____ Zip Code _____

Employment Information

You are currently: Employed / Unemployed / Student / Pre-school child / Retired
If you are employed, please provide the following information regarding your employer:
Employer Name: _____
Work Address: _____
Work Phone #: (_____) _____ - _____

Personal communication and Emergency Contact Information

Home Phone #: (_____) _____ - _____ Cell Phone #: (_____) _____ - _____
May we leave a message on your phone? Yes / No **If Yes, Cell / Home / Work**
May we send you an email, fax or text documents or messages? Yes / No
Email: _____ @ _____ . _____ Fax#: (_____) _____ - _____
Emergency contact name: _____
Emergency contact phone #: (_____) _____ - _____
Emergency contact relation: Spouse / Parent / Child / Friend / Sibling / Other _____

How were you referred to our office?

Medical Doctor / Relative / Friend / Coworker / Internet / Our Office Web site / Insurance

Who may we thank for referring you?: _____

Are you here because of an Auto Accident or Workers Comp claim?

Is this visit due to an automobile accident: Yes / No

Is this visit due to a worker's compensation issue: Yes / No

If yes, please provide us with a copy of your insurance card, claim number and lawyer contact information

Insurance and Guarantor Information - *Please provide your insurance card or cards and photo ID*

Do you have health insurance: Yes / No, If yes, please continue below.

Name of Insurance Company: _____

Insurance ID #: _____

Are you the primary policy holder? Yes / No, If No please complete below

The primary policy holder is my: Spouse / Parent / Domestic Partner

If you are NOT the primary policy holder, please provide the following;

Primary policy holder's full name: _____

Primary policy holder's date of birth: ____/____/____

Primary policy holder's address: Same as mine: Yes / No

If No, please provide address: _____

Do you have a secondary insurance: Yes / No

If Yes, are you the secondary policyholder? Yes / No, If No, please complete below,

Secondary policy holders full name: _____

Secondary policy holder's date of birth: ____/____/____

Secondary policy holder's address: Same as mine: Yes / No

If No, please provide insured's address:

Primary Medical Doctor

Who is your Primary Medical Doctor? _____

Primary Doctor's Address: _____

What is their office phone number? (_____) _____ - _____

Do you see a specialist (endocrinologist, cardiologist, vascular surgeon)? _____

Dr Name: _____ Date of last visit: _____

Pharmacy Information

What **local** pharmacy do you use? _____

What street, town and state is your **local** pharmacy in? _____, _____, _____

May we electronically request your RX history from your pharmacy? Yes / No

By signing below, I authorize ProActive Foot & Ankle Associates (ProActive) to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at ProActive, and it may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my ProActive medical record. I also give permission for ProActive to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature

Allergy Questions

Do you have any material, medication or food allergies? Yes / No

If Yes, what is your allergy? (Circle all that apply)

epinephrine / aspirin / codeine / penicillin / cortisone / iodine / sulfa / tetracycline

erythromycin / Demerol / morphine / latex / Levaquin / Cipro / seafood / adhesive

Other: _____ Other: _____ Other: _____ Other: _____

Current Prescription Medication

Are you currently taking any prescription or over-the-counter medications? Yes / No

If Yes, Please complete below;

Name of Medication

Name of Medication

Review of Systems

Do you **CURRENTLY** have any of the following problems? Yes / No (If Yes please circle all that apply)

<u>General Health:</u>	Fever	Chills	Weakness	Weight loss
<u>Allergic:</u>	Coughing	Wheezing	Hives	Recurrent Infection
<u>Cardiovascular:</u>	Swelling of legs	Leg pain	Ulcers on legs	Chest pain
<u>Endocrine:</u>	Excess Urination	Increased Thirst	Sweats	Weight Loss
<u>Eyes:</u>	Blurred Vision	Cataract	Tingling	Unsteady Gait
<u>Hematologic:</u>	Swollen Glands	Lumps	Blood Clots	Bruises Easily
<u>Musculoskeletal:</u>	Joint Pain	Muscle Cramps	Back pain	Paralysis
<u>Neurological:</u>	Numbness	Burning	Tingling	Unsteady Gait
<u>Psychiatric:</u>	Memory Loss	Depression	Nervousness	Anxiety
<u>Skin:</u>	Itching	Lumps	Nail Changes	Rashes

Height: _____

Weight: _____

BP: _____

Shoe Size: _____

Medical Conditions

Do you have any medical conditions? Yes / No

If Yes, please circle all that apply, **even if you are taking medication for the condition**

- | | | |
|----------------------------|-----------------------------|--------------------------|
| Alzheimer's or memory loss | anemia | anxiety |
| atrial fibrillation | back problems | bleeding disorder |
| cancer, type _____ | COPD | congestive heart failure |
| coronary artery disease | diabetes | GERD |
| glaucoma | hearing loss | heart valve problem |
| heart attack or MI | heart problem | hepatitis |
| high cholesterol | HIV or AIDS | hypertension |
| kidney disease | liver disease | migraines |
| Parkinson's | peripheral arterial disease | peripheral neuropathy |
| prostate problem | psoriasis | Raynaud's |
| rheumatoid arthritis | seizure disorder | skin cancer |
| stroke or TIA | thyroid problem | vision problems |
| other _____ | other _____ | other _____ |

Surgeries

Have you had any surgeries? Yes / No (If Yes, please circle all that apply)

- | | | |
|-------------------------------|-------------|-----------------|
| appendix | back | bariatric |
| bladder | bypass legs | bypass heart |
| cataract | colon | gallbladder |
| heart valve | kidney | liver |
| Organ transplant, organ _____ | prostate | replacement hip |
| replacement knee | thyroid | vein stripping |
| other _____ | other _____ | other _____ |

Social and Immunization History

Smoking

Do you currently smoke cigarettes? Yes / No

If yes, how many packs per day do you smoke? Less than 1 / 1 pack / > 1 pack per day

Have you smoked in the past? Yes / No

If yes, when did you quit? This year / 1-5 years ago / More than 5 years ago

Do you drink alcohol regularly? Yes / No

If yes, how much? Socially / 1 drink per week / 1 drink per day / 1 or more per day

Flu & Pneumonia Vaccine

Have you had a flu shot this year? Yes / No

If yes, when, _____

Have you had a pneumonia (pneumococcal pneumonia) vaccine? Yes / No

If yes, when, _____

Have you had a COVID vaccine this year? Yes / No

If yes, when, _____

Podiatric Problem

Can you describe what type of foot, ankle or leg problem you are having?

Which of foot, ankle or leg is the problem on: left / right / both

Where in particular is the problem? _____

When did the problem begin? today / ___ days ago / ___ weeks ago / ___ months ago / ___ years ago

Do you remember a particular injury or cause? Yes / No

If yes, explain; _____

Did the problem begin suddenly or gradually

Have you had any prior treatment for this problem? Yes / No

If yes, explain; _____

If painful, how would you describe the pain?: dull sharp aching burning shooting throbbing other,

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, _____ hereby authorize ProActive Foot and Ankle Associates (the practice) to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize the practice to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I request payment from my insurance company or Medicare to be made directly to the practice. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. This authorization may be revoked at any time by me with written notice to the practice. Most insurance plans require that patient authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient can not sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We can not call your doctor to request a referral on your behalf. If you have a co-pay, it is due at the time of the visit. If you fail to pay your copay at the time of the visit, a \$5.00 surcharge will be applied for each month until the balance is paid. We do not bill for copay.

Regardless of your insurance plan, you are financially responsible for payment. If the claim we submit is not paid by your insurance plan within 90 days, we consider the claim as "not covered" by your plan, and you will become financially responsible. Should your account go to collection, you agree to pay any and all expenses, including collection fees or percentages.

Acknowledgement of Practices Notice of Privacy Practices

By signing my name below, I acknowledge that I am aware that a copy of the Notice of Privacy Practices (NPP) is available to me (copy located in waiting room) and I have had the opportunity to read, if I so chose, and understand the Notice of Privacy Practices (NPP) and agree to its terms. I may request and receive a printed copy of the NPP upon request.

MEDICARE PATIENTS ONLY: I request that payment of authorized medical and surgical benefits and supplies be made to ProActive Foot and Ankle Associates on my behalf or any covered dependants. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS: As a self-paying patient I understand that I am responsible for and will pay for all medical/podiatric services at the time of the visit.

I have read, understand and agree to the above.

_____/_____/_____

Today's Date

Patient's Name (Please Print)

Patient's Signature

If under 18 years old, Patient's or Guardians Name
(Please Print)

If under 18 years old, Patient's or Guardians Signature