PODIATRIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age Birthdate

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Email _____

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ 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 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.

_____ _____

Relationship Date

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐Yes ☐No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

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

_____

_____

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

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

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Medicine		Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
or Drugs	☐Yes ☐No	Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves		Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
or Joints	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chest Pain	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

_____

_____

6. MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐Yes ☐No

7. ALLERGIES

☐Adhesive/Tape
☐Anticoagulant Therapy
☐Aspirin
☐Codeine
☐Demerol
☐Iodine
☐Local Anesthetics
☐Novocaine
☐Penicillin
☐Sea foods
☐Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

HB PODIATRY GROUP
17822 BEACH BLVD., SUITE 407
HUNTINGTON BEACH, CA 92647
T: 714-841-3213
F: 714-841-0434

NOTICE OF PRIVACY PRACTICES

Patient Name: _____

(Please print)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is "protected Health Information" (PHI) under a federal health privacy law, for the purpose of treatment, payment and healthcare operations. PHI is basically health information that is identifiable to an individual and this is transmitted or maintained in any form or medium, including oral, paper, or electronic, by a health care provider. (Healthcare provide includes any person or organization who furnishes, bills, or is paid for health care in the normal course of business. Provider includes physicians and all staff.) PHI can be more than just medical records and charts. PHI includes information that relates to treatment, health condition, payment, and even demographics information such as name, address, and age. Disclosed PHI will cover all dates of service performed by the doctors and staff from HB Podiatry Group, at the office or patient's home.

Print name: _____
(For personal representative, please indicate your relationship)

Signature: _____

Date: _____

Date of Birth: _____

Social security number: _____

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ASSIGNMENT OF BENEFITS

- I authorize and direct my insurance company or benefit program to provide a full and complete copy of the benefits and services available to me under my health care plan, program and/or insurance, including but not limited to all terms, conditions, limitations and exclusions of coverage, just as if I had requested such information.

- I am financially responsible for any co-pays, deductibles, or patient responsibility for all office visits, services, or supplies provided at time of visit, and for all office visits, services, or supplies which are not authorized, or are denied per insurance company, or if I have no insurance benefits at time of service.

- I authorize and direct my insurance carrier to pay medical benefits directly to HB Podiatry group, Inc.

- I understand that if I receive payments due to my physician for charges I have incurred for medical treatment, it is my responsibility to remit to HB Podiatry Group ASAP.

- I understand and agree that if I fail to cooperate with my insurance company in processing my claims, and payment is denied, I am financially responsible for the full charges.

Patient signature: _____
(For personal representative, please indicate your relationship)

Print name: _____