

PATIENT REGISTRATION FORM

- Please provide a copy of your current insurance cards.
- Co-Pay, Co-Insurance & Deductibles are expected at the time of service.

Patient Information:

Last Name: _____

Date of Birth: _____

First Name: _____

Patient Gender: Male ___ Female ___

Middle Name: _____

Marital Status: _____

Address: _____

Student: Yes ___ No ___

City, State, Zip: _____

Employer Name: _____

Home Phone#: (____) _____

Address: _____

Cell Phone#: (____) _____

City, State, Zip: _____

Social Security #: _____

Phone: (____) _____

Occupation: _____

Referring Physician:

Name: _____

Family/PCP Physician:

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Phone#: (____) _____

Phone: #(____) _____

Fax#: (____) _____

Fax#(____) _____

Guarantor Information:

(Person responsible financially and/or patient is a minor)

Last Name: _____

Date of Birth: _____

First Name: _____

Social Security #: _____

Middle Name: _____

Employer Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Home Phone#: (____) _____

Phone #: (____) _____

Relationship to Patient: _____

Emergency Contact:

****Please list name of someone **not** living in your household****

Name: _____

Address: _____

Phone#: Wk.(____) _____ Hm.(____) _____

Relationship to Patient: _____

INSURANCE INFORMATION:

*** Insurance Cards/Documentation must be given to front desk at time of service ***

Will this treatment be done as a result of:

- **Workers Compensation Injury:** Yes ___ No ___
 Date of Injury: _____ WC Claim #: _____
 Managed Care Organization: _____
 Claims Representative: _____ Phone #:(____) _____
- **Auto/Personal Accident:** Yes ___ No ___
 Date of Injury: _____ Claim #: _____
 Auto/Home Owners Insurance: _____
 Claims Representative: _____ Phone #:(____) _____

Health Insurance:

Primary Insurance: _____
 Policy/ID #: _____
 Group #: _____
 Insured/Subscriber: _____
 Social Security #: _____ Date of Birth: _____
 Relationship to Patient: _____
 Insured Employer: _____
 Effective Date: _____ Referral Required Yes ___ No ___

Secondary Insurance _____
 Policy/ID #: _____
 Group #: _____
 Insured/Subscriber: _____
 Social Security #: _____ Date of Birth: _____
 Relationship to Patient: _____
 Insured Employer: _____
 Effective Date: _____ Referral Required Yes ___ No ___

INSURANCE AUTHORIZATION/ASSIGNMENT (PLEASE READ & SIGN)

I hereby authorize the physician to furnish information to my insurance carrier concerning my condition and treatment. I hereby assign to the physician all payments for medical service rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance carrier. I agree to be held responsible for collection processing fees that may be added to my account if collection action occurs.

Signature _____ Date _____
 (If the patient is a minor, the legal guardian must sign)

PATIENT MEDICAL INFORMATION

What condition(s) are you being seen for today?

Please **circle** any of the following conditions that you currently have or have had.

- | | | |
|---------------------|-----------------------|-----------------------|
| High Blood Pressure | Respiratory Condition | Arthritis |
| Low Blood Pressure | Asthma | Circulatory Condition |
| Heart Condition | Seizures | Liver Condition |
| Kidney Condition | Bleeding Tendencies | Venereal Disease |
| Diabetes | Gout | Infectious Disease |
| Allergies | Thyroid | HIV + |

Other:

Have you had metal (ex. plates, screws, rods) implant surgery? Yes ___ No___

Height: _____ Weight: _____ Shoe Size: _____ Mens: _____ Womens: _____

Narrow: ___ Regular: ___ Wide: _____

Smoker? Yes ___ No ___ If yes, how long? _____ How many packs a day? _____

Sensitive to Latex? Yes ___ No _____

Sensitive to Adhesive? Yes___ No_____

List any drug Sensitivities/Allergies:_____

List Prescription Medications Currently Taking: (Attach list if additional space needed)

Total Foot and Ankle of Ohio does not honor advanced directives, and Total Foot and Ankle of Ohio will call 911 to provide life support to any patient in distress. After treatment, the patient will be turned over to their treating physician for continuing care

Place Patient Identification Label Here

Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Privacy Notice for [Provider Name].

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative Signature

Date

Personal Representative's Relation to Patient

ABOVE - Patient or Personal Representative Use Only
BELOW - Provider Use Only

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement
- Patient was unable to sign because:

- There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- Other reason, described below:

Employee Signature

Date