EASTOVER FOOT & ANKLE

PATIENT REGISTRATION

Thank you for choosing our office! Please complete all pages.

PATIENT INFORMATION

Patient Name:			Driver's License Number
Home Address:			
City:		State:	Zip:
Sex:	Date of Birth:	SS#:	Marital Status: S,M,O or minor
E-mail:		Home Phone:	Cell Phone:
Race	Ethnicity		Language
Employer Name			Work Phone:

PERSON RESPONSIBLE FOR PAYING THE BILL

Name:			SS#:
Home Address:		City	State Zip
Employer Name:			Work Phone:

FAMILY PHYSICIAN INFORMATION

Name:	Phone:
Did your family physician refer you to this practice? What is the date you last saw this doctor?	

HEALTH INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier:		
Policy Number:		
Group Number:		
Effective Date:		
Copay:		
Policyholder Name:		
Date of Birth:		
Sex:		
Patient Relationship		

EMERGENCY INFORMATION

Emergency Contact:	
Emergency Contact's Phone #:	Emergency Contact's Relationship to Patient:

EASTOVER FOOT & ANKLE

REASON FOR TODAY'S VISIT

Reason for today's visit:	Is today's visit due to an accident or a work related injury?
Please rate your pain from 1-10 (10 being highest)	Former Podiatrist:

FAMILY HISTORY

Please indicate which of your relatives (living or deceased) have had any of the following diseases:

Cancer:	Diabetes:
Heart Trouble:	High Blood Pressure:
Kidney Disease:	Mental/Emotional Disease:
Strokes:	Arthritis:

MEDICAL HISTORY

Have you ever had any of the following? Please **CIRCLE** all those that apply:

Allergies/Hay fever	Diabetes	Joint pain or stiffness	Stomach Trouble
Anemia or abnormal bleeding	Double Jointed	Kidney disease or stones	Stroke
Arthritis	Fainting	Liver Disease	Swelling in feet or ankles
Asthma	Fracture history	Low back pain	Thyroid problems
Cancer	Gall bladder or Gall stones	Lungs (Pneumonia, T.B., etc.)	Trouble w/ vision
Chest Pain	Glaucoma	Mental / Emotional Disease	Other illnesses or problems
Circulation	Gout	Numbness in feet or legs	Do you smoke? How Much?
Cramps in feet or legs	Heart Problems	Shortness of Breath	Do you take any illegal drugs?
Depression	High Blood Pressure	Skin problems	Do You drink alcohol? How much?
Are you pregnant? YES or NO	Convulsions	HIV/AIDS	Other:

SURGICAL HISTORY

Please list all serious illnesses, operations, and other hospitalizations you have experienced, please include dates:

Is there any thing you wish to tell your physician privately? ____Yes _____No

How did you hear about us? _____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date_____

Signature of Patient, Parent or Guardian

EASTOVER FOOT & ANKLE

CURRENT LIST OF MEDICATIONS

NAME OF DRUG	Dosage	Medical condition

Drug Allergies

_____

_____

Name of Pharmacy	Address	Phone number

_____

CONSENT TO TREAT: I request and give consent to Eastover Foot & Ankle, P.A., it's employees and all other persons caring for me to treat me in ways they judge are beneficial to me for my health and well being. I understand that this care may include tests, examinations, medical and surgical treatment, and consultations with appropriate specialists. No guarantees have been made to me about the outcome of this care.

Signature:_____

FINANCIAL AGREEMENT: I understand that payment is due at time service is provided. I understand that Eastover Foot & Ankle, P.A., will bill most insurance carriers as a courtesy to me if proper paperwork is provided to them. Eastover Foot & Ankle, P.A. will also bill most secondary insurance companies for me if applicable. I understand that my co-payments and deductibles are due at the time of service. I understand that I am responsible for the payment of all charges not paid by my insurance company.

Signature:_____

ASSIGNMENT OF BENEFITS: I authorize payment directly to Eastover Foot & Ankle of any benefits, which would otherwise be payable to me for their services as described, realizing I am responsible to pay non-covered services. I also authorize Eastover Foot & Ankle, P.A. to release any information acquired in the course of my treatment necessary to process insurance claims. I authorize the use of this signature on all insurance forms and submissions.

Signature:_____***Date:***_____

MEDICARE CERTIFICATION: The information provided by me in applying for payment for Social Security benefits is true and correct. I authorize the physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediate carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

- Medicare regulations require that I am informed in advance of any service that may not be covered. **The following services may not be covered:**
  - **ROUTINE FOOT CARE**: The trimming, cutting or debridement of corns, nails and calluses is not a covered service. *Exceptions to the rule are*: patients with peripheral vascular disease that are being treated by their primary physician for this condition. Medicare will pay for nail debridement for patients who suffer from vascular disease every 61 days. If you receive treatment more frequently, you will be responsible for the services rendered.
  - **OTHER SERVICES**: Post Operative shoes, supplies such as bandages, medications, and shoe inserts, prescription orthotics and custom orthopedic shoes, lab handling fees.

    Signature_____

NOTICE OF PRIVACY: Eastover Foot and Ankle is offering a written copy of the Notice Of Privacy Practices.

_____ I do not want a copy

_____I have requested and received a copy

_____ _____

Patient name-Signature Date