Alexandria Family Podiatry
Phone: 703-823-2357 Fax: 703-823-1572
www.alexandriafamilypodiatry.com

NEW PATIENT REGISTRATION FORM

First: _____ Middle Initial: _____Last _____
(as it appears on insurance policy) (as it appears on insurance policy)

Address (Billing): _____ Apt. No.: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____/_____/_____

***** Check box below for the *preferred* contact number:** (Please ensure voice mailboxes are set up and cleared to take messages.)

☐ Cell: _____ ☐ Home: _____ ☐ Work:_____

Email Address: _____ Gender: ☐ Male ☐ Female

Marital Status:

☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Legally Separated
☐ Life Partner
☐ Other

How did you hear about us? (Please check all that apply)

☐ Google Search
☐ Insurance carrier's provider directory
☐ Yelp
☐ Referring physician (Name: _____)
☐ Another patient (Name: _____)
☐ Other (Please explain: _____)

Primary care physician: First:_____ Last: _____
City:_____ State: _____

Emergency contact: First: _____ Last: _____
Phone: _____ Relation to patient: _____

Preferred Pharmacy: We are able to transmit prescriptions electronically to most pharmacies.

Pharmacy name: _____
Pharmacy address: _____ City: _____ State: _____
Pharmacy phone: _____

FINANCIAL INFORMATION ***(Please present your insurance card and photo ID to the front office staff.)***

Do YOU (the patient) have health insurance?

☐ Yes
☐ No

If you (the patient) have health insurance, are <u>YOU</u> the policy holder? ☐ Yes ☐ No

If no, please provide policy holder information as it appears on the insurance policy:

Name: _____ Date of Birth: _____ Relation to Patient: _____

Financially responsible party: (please check one) ☐ self ☐ other - complete information below

First Name_____ Last Name: _____ Relation to Patient: _____

MEDICAL INFORMATION

Medications: In the space below, please list below any and all medications that you are currently taking (or provide a separate list of your medications). If you are **NOT** taking any medications, please check the box below to indicate this:

☐ **I am currently NOT taking any medications.**

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____

Drug allergies: Please list any and all drug allergies as well as the reaction(s) that you have experienced. If you have NO KNOWN druge allergies, please check the box below to indicate this:

☐ **I have NO KNOWN drug allergies.**

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____
5. _____ Reaction: _____

Medical History: Please check if you have or have had any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer
- ☐ Cardiac Pacer
- ☐ Cardiovascular
- ☐ CHF
- ☐ Colitis
- ☐ COPD
- ☐ CRF
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gastric Ulcer
- ☐ Gastrointestinal
- ☐ GERD
- ☐ Gestational
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Joint Pain
- ☐ Kidney Infections
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Old MI
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Pneumonia
- ☐ Progressive
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ STD
- ☐ Terminal Illness
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis
- ☐ _____
- ☐ _____
- ☐ _____

Surgical Procedures: Please check if you have had any of the following procedures:

☐ I have no prior surgical history.

- ☐ Appendectomy
- ☐ Breast lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Cone Biopsy
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Oophorectomy
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal ligation
- ☐ Other _____

Podiatric History: Please check if you have had or have any of the following:

☐ Arthritis	☐ Flat Feet	☐ Heel Spurs
☐ Athlete's Foot	☐ Foot Ulcers	☐ Ingrown Toenails
☐ Bunions	☐ Fungal Toenails	☐ Liver Disease
☐ Corns/Calluses	☐ Gout	☐ Plantar Fasciits
☐ Difficulty Healing	☐ Hammertoes	☐ Plantar Warts

Hospitalizations: Please list/describe any recent hospitalizations:

SOCIAL HISTORY

Smoking Status:
- ☐ Current: Everyday smoker (# of packs per day ____)
- ☐ Current: Some day smoker
- ☐ Former smoker (date quit smoking: _____)
- ☐ Never smoker

Alcohol Use:
- ☐ Non-drinker
- ☐ Occasional
- ☐ Social drinker
- ☐ Moderate consumption
- ☐ Heavy alcohol consumption
- ☐ Recovering alcoholic

Caffeine Use:
- ☐ 0 servings per day
- ☐ Occasional
- ☐ 1 serving per day
- ☐ 2 servings per day
- ☐ 3 servings per day
- ☐ 4 or more servings per day

Exercise Habits:
- ☐ Sedentary
- ☐ Moderate exercise: < 3 times/week
- ☐ Moderate exercise: > 3 times/week
- ☐ Strenuous exercise: < 3 times/week
- ☐ Strenuous exercise: > 3 times/week

Race:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native American/Other Pacific Islander
- ☐ White
- ☐ Prefer Not to Answer

Primary Language Spoken:

☐ English	☐ Hindi	☐ Russian
☐ Arabic	☐ Italian	☐ Spanish
☐ Chinese	☐ Japanese	☐ Tagalog
☐ French	☐ Korean	☐ Tamil
☐ German	☐ Polish	☐ Vietnamese
☐ Greek	☐ Portuguese	☐ other _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Answer

- **Height:** _____
- **Weight:** _____
- **Shoe Size:** _____

Women, are you pregnant or breastfeeding?
- ☐ YES
- ☐ NO

Skin Changes
- ☐ bruise easily ☐ itching/rash ☐ changes in moles ☐ scars
- ☐ scars that won't heal

Please describe the reason for your visit today:

ALEXANDRIA FAMILY PODIATRY
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We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

For your convenience, we accept cash, check, and/or visa, MasterCard, and Discover. If you have health insurance, you will need to pay your portion (co-pay and/or deductible) at the time of service. It is your responsibility to know what is required by your insurance policy.

Insurance is a contract between YOU and your insurance company. We are NOT a party to this contract. We will assist you as much as possible in obtaining prior authorization, referrals or answers to your questions, but it is ultimately YOUR responsibility to communicate with your insurance company to determine eligibility, requirements for co-payments, deductibles, covered services, referrals, etc. Disagreements and misunderstandings with your insurance carriers are not between this practice and the insurance company, but rather between YOU and the insurance company. Problems and issues can be avoided when you are personally involved. Your carrier is far more likely to respond to requests or complaints directly from you since you pay the premiums. Remember, you are responsible for the timely payment of your account.

CONTRACT TO PAY

- In consideration of professional services rendered to the patient named below, I/we agree to pay co-pay, deductible at the time of services. I/We understand that I/we are financially responsible for all charges whether they are eligible for payment by my insurance carrier or not. I/we authorize the doctor to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under my insurance plan, I/we agree to pay the difference.

- I/We understand that I/we are required to cancel any appointments **at least 24 hours in advance of scheduled appointment.** If I/we fail to cancel within 24 hours, I/we understand that I/we may be charged a fee of $60.00. This charge is not reimbursable by my insurance company and is my sole responsibility.

- I/We understand that my account will be turned over to a collections agency if NO real attempt of payment has been made in a reasonable amount of time.

- I/We hereby authorize Alexandria Family Podiatry to administer such medications and immunizations and to perform such diagnostic/medical/surgical procedures as may be necessary for proper health care. I/We are aware that any major lab work may be sent to an outside lab, and I/We will receive an additional bill from that facility. I/We are aware that pathology may be sent to an outside pathologist for a second opinion.

- Please check box to confirm that my pathology results may be given to someone other than myself either over the phone or in person. (i.e. spouse, parent, other doctor) . ☐ Yes ☐ No

- My/Our signature below signifies my/our understanding of the terms and conditions of this Financial Policy, contract to pay for medical services and Release of Medical Information. Should the balance due be left unpaid after 90 days, and it becomes necessary to refer my account to a collections agency, I agree to pay 33 1/3% collection charges, and 18% interest per annum on the unpaid balance. This includes, but is not limited to all court costs and reasonable attorney fees.

- I/We acknowledge that a notice of privacy practices has been provided for my information and review. (Please request at front desk)

–
_____
Patient Signature (If patient is a minor, signature of parent/guardian is required here.) Date

_____
Printed name

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/We certify that I/we have received a copy of Alexandria Family Podiatry Notice of Privacy Practices. This notice describes the uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of Alexandria Family Podiatry health care operations. The Notice of Privacy Practices also describes my rights and Alexandria Family Podiatry's duties with respect to my protected health information. The Notice of Privacy Practices is located in the medical records area of our office. Please request a copy from any staff member to review.

Alexandria Family Podiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I/We may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

In general, the HIPAA privacy rule gives me/us the right to request a restriction on uses and disclosures of my protected health information (PHI). I/We are also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to my work office instead of the my home, for example.

I wish to be contacted in the following manner: (check all that apply)

☐ **Mobile Phone →** ☐ Consent to leave message with detailed information **OR**
☐ Please leave message with call-back number ONLY

☐ **Home Phone →** ☐ Consent to leave message with detailed information **OR**
☐ Please leave message with call-back number ONLY

☐ **Work Phone →** ☐ Consent to leave message with detailed information **OR**
☐ Please leave message with call-back number ONLY

☐ **Other Phone:** _____
☐ Consent to leave message with detailed information **OR**
☐ Leave message with call-back number ONLY

WRITTEN COMMUNICATION*: (check all that apply)*

☐ **Email Address:** _____
☐ Consent to correspond by E-mail to the address above

☐ **Home address →** ☐ Consent to correspond by mail to my home address

☐ **Work address →** ☐ Consent to correspond by mail to my work address

☐ **Fax Number:** _____
☐ Consent to fax correspondence to the number above

_____
Patient Signature (If patient is a minor, signature of parent/guardian is required here.) Date

_____
Printed Name