FOOT AND ANKLE CENTER OF THE CENTRAL COAST

PETER C. FILLERUP D.P.M. CASEY B. FILLERUP D.P.M.

PATIENT REGISTRATION

Date: _____

Patient's Name: _____
(Last) (First) (Middle Initial)

Patient's DOB:_____ AGE Sex: M F Shoe Size: _____

I request that all communications to me (via phone, mail or otherwise) by The Foot an Ankle Center of the Central Coast (Dr. Fillerup's Office and/or his staff) be handled in the following manner:

Address for written communications: _____
Number Street City State Zip Code

Billing Address (if different from above): _____
City State Zip Code

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Where do you prefer to receive calls? _____ **May we leave a message?** _____

Occupation: _____ Employer: _____

Name of Pharmacy used: _____ Whom may we thank for referring you? _____

PATIENT MEDICAL HISTORY

Have you ever had/have the following conditions:
Circle those that apply.

Diabetes	Arthritis	Excessive Bleeding	Asthma
Tuberculosis	Fractures	Blood Clots	Bronchitis
Cancer	Polio	Arteriosclerosis	Emphysema
Heart Disease	Stroke	High/Low Blood Pressure	Ulcers
Kidney Disease	Gout	Anemia	Pregnant (Currently)
Back Problems	Hepatitis A B C	Rheumatic Fever	HIV/AIDS
Thyroid Disorder	Ankle Swelling	Epilepsy	Other:_____

Which family member has had?: Heart Disease Diabetes Asthma Cancer Stroke

_____

Do you smoke? _____ Yrs.? _____Do you drink alcohol?_____How often?_____

Please list any allergies to any medications? _____

Current Medications: _____

Previous Surgeries: _____

Primary Care Doctor: _____ Last visit at Primary Care Doctor:_____

PODIATRIC HISTORY

Please indicate primary foot problem you are now experiencing: (please circle)

Ankle Pain Athlete's Foot Corns/Calluses Nail Fungus Flat Feet Heel Pain Warts on foot/ankle

Tired Feet Numbness in feet Swelling in feet Bunion Pain Other:_____

INSURANCE INFORMATION

Primary Insurance	***Secondary Insurance***
Insurance Company _____	Insurance Company_____
Subscriber's Name _____	Subscriber's Name _____
Subscriber # _____ Group #_____	Subscriber # _____ Group # _____
Copay _____ Deductible _____	Copay _____ Deductible _____
Relationship to Insured _____	Relationship to Insured _____

AGREEMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage with (name of insurance company) _____and assign directly to Dr. Fillerup all insurance benefits, if any, otherwise payable to me for services rendered.

Payment/Copay is requested at the time of each visit. We accept personal checks, VISA, MasterCard, cash and most insurance plans. ***It is extremely important that you bring your insurance cards to your appointment so that we may obtain the necessary and correct information to file claims for you.***

It is difficult to know all the specifics about each insurance plan. It is your responsibility to obtain referrals and determine if we are a provider within your plan. However, complete payment is ultimately your responsibility.

HMO'S / PPO'S

It is necessary for you to check with your HMO and/or PPO for any special requirements. If you have an HMO and /or PPO that requires a referral from your Primary Care Physician (PCP), we ask that you call your PCP to verify that one has been done. We ask that you bring a copy of the referral to your appointment. If you arrive without this information you will be asked to reschedule your appointment until a referral has been completed.

_____	_____	_____
Responsible Party Signature	*Relationship to Patient*	*Date*

I hereby give permission to Dr. Fillerup to administer treatment as agreed to be deemed necessary in the diagnosis and/or treatment of my Podiatric condition.

_____	_____	_____
Responsible Party Signature	*Relationship to Patient*	*Date*

I acknowledge that I was offered a copy of the *Notice Of Privacy Practices*, and that I have read (or had the opportunity to read if I so choose) and understand the notice:

Signature of Patient or authorized representative:_____ Date:_____

Peter C. Fillerup, D.P.M. Casey B. Fillerup, D.P.M.
Foot & Ankle Center of the Central Coast
1145 E. Clark Ave. Ste. A
Santa Maria, CA 93455

Name: _____ Date of Birth: _____

Address: _____ Apt.: _____ City: _____ Zip: _____

Home Phone:_____Cell: _____ Work: _____

PRIMARY CARE PHYSICIAN (PCP) NAME: _____

Please Read & Initial # 1-8

_____1. We are required by your insurance to have an annual updated registration.

_____2. Although it is difficult to know all the specifics about each insurance plan, it is your responsibility to know if we are a provider within your plan.

_____3. Payment, Copay, Deductibles, and Share of Cost are requested at the time of each visit. Please be aware of the amounts contracted with your insurance plan. You as the patient or guardian are responsible for all charges, regardless of insurance coverage.

_____ 4. If you have an HMO that requires a referral from your primary care physician, we ask that you call your PCP to verify that one has been provided for each office visit.

_____5 . Our office charges $40.00 for any missed appointments, if not cancelled within 24 hours.

_____ 6. Charges for medical forms and completion are as follows $40.00 for State Disability EDD Initial form, continuation of EDD form, any Employer forms, other Disability form, and DMV form, these forms will be completed within 5 to 10 business days.

_____ 7. At this time we will not be accepting any Workman's Comp related injuries or insurance claims.

_____ 8. Accounts sent to collections will not be reappointed to our office.

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Fillerup. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission.

Patient or Responsible Party Signature: _____ Date: _____