Complete Foot & Ankle
Proud to keep you healthy, active, and pain-free!

Patient Registration Form

Personal Information Today's date:_____

Patient's First Name: _____ MI:____ Last Name: _____

Date of Birth: _____/_____/_____ Gender: Male / Female/ Other

Social Security #: _____-_____-_____ Marital Status: Married / Single / Divorced / Widowed

Race: White / Asian / African American / Hispanic / Latino / Pacific Islander / Native American

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

What is your preferred language? English / Spanish / Mandarin / Italian / Other:_____

Home Address:_____ City:_____ State:_____Zip Code _____

Employment Information

You are currently: Employed / Unemployed / Student / Pre-school child / Retired

If you are employed, please provide the following information regarding your employer:

Employer Name:_____

Work Address:_____

Work Phone #:(_____) _____-_____

Are you a member of a union? Yes/No **If Yes**, Local:_____

Personal communication and Emergency Contact Information

Home Phone #: (_____) _____-_____ Cell Phone #:(_____) _____-_____

May we leave a message on your phone? Yes / No **If Yes**, Cell / Home / Work

May we send you an email, fax or text documents or messages? Yes / No

Email:_____@_____._____ Fax#: (____) _____-_____

Emergency contact name:_____

Emergency contact phone #: (_____) _____-_____

Emergency contact relation: Spouse / Parent / Child / Friend / Sibling / Other_____

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Patient Name:_____

How were you referred to our office?

Medical Doctor / Relative / Friend / Coworker / Internet / Our Office Web site / Insurance

Who may we thank for referring you?:_____

Are you here because of an Auto Accident or Workers Comp claim?

Is this visit due to an automobile accident: Yes / No

Is this visit due to a worker's compensation issue: Yes / No

If yes, please provide us with a copy of your insurance card, claim number and lawyer contact information

_____

Insurance and Guarantor Information - *Please provide your insurance card or cards and photo ID*

Do you have health insurance: Yes / No, If yes, please continue below.

Name of Insurance Company:_____

Insurance ID #: _____

Are you the primary policy holder? Yes / No, If No please complete below

The primary policy holder is my: Spouse / Parent / Domestic Partner

If you are NOT the primary policy holder, please provide the following;

Primary policy holder's full name:_____

Primary policy holder's date of birth: _____/_____/_____

Primary policy holder's address: Same as mine: Yes / No

If No, please provide address: _____

Do you have a secondary insurance: Yes / No

If Yes, are you the secondary policyholder? Yes / No, If No, please complete below,

Secondary policy holders full name:_____

Secondary policy holder's date of birth: _____/_____/_____

Secondary policy holder's address: Same as mine: Yes / No

If No, please provide insured's address:

_____

Patient Name:_____

Primary Medical Doctor

Who is your Primary Medical Doctor?_____

Primary Doctor's Address:_____

What is their office phone number? (_____) _____-_____

Do you see a specialist (endocrinologist, cardiologist, vascular surgeon)? _____

Dr Name:_____ Date of last visit:_____

Pharmacy Information

What **local** pharmacy do you use?_____

What street, town and state is your **local** pharmacy in? _____, _____, _____

May we electronically request your RX history from your pharmacy? Yes / No

By signing below, I authorize Complete Foot & Ankle Associates to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Complete, and it may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my Complete medical record. I also give permission for Complete to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Patient Signature

Allergy Questions

Do you have any material, medication or food allergies? Yes / No

If Yes, what is your allergy? (Circle all that apply)

epinephrine / aspirin / codeine / penicillin / cortisone / iodine / sulfa / tetracycline

erythromycin / Demerol / morphine/ latex / Levaquin / Cipro/ seafood/ adhesive

Other:_____ Other:_____ Other:_____ Other:_____

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Patient Name:_____

Current Prescription Medication

Are you currently taking any prescription or over-the-counter medications? Yes / No

If Yes, Please complete below;

Name of Medication	Name of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

Do you **CURRENTLY** have any of the following problems? Yes / No (If Yes please circle all that apply)

General Health:	Fever	Chills	Weakness	Weight loss
Allergic:	Coughing	Wheezing	Hives	Recurrent Infection
Cardiovascular:	Swelling of legs	Leg pain	Ulcers on legs	Chest pain
Endocrine:	Excess Urination	Increased Thirst	Sweats	Weight Loss
Eyes:	Blurred Vision	Cataract	Tingling	Unsteady Gait
Hematologic:	Swollen Glands	Lumps	Blood Clots	Bruises Easily
Musculoskeletal:	Joint Pain	Muscle Cramps	Back pain	Paralysis
Neurological:	Numbness	Burning	Tingling	Unsteady Gait
Psychiatric:	Memory Loss	Depression	Nervousness	Anxiety
Skin:	Itching	Lumps	Nail Changes	Rashes

Height: _____ **Weight:_____** **BP:_____** **Shoe Size: _____**

Patient Name:_____

Medical Conditions

Do you have any medical conditions? Yes / No

If Yes, please circle all that apply, **even if you are taking medication for the condition**

Alzheimer's or memory loss	anemia	anxiety
atrial fibrillation	back problems	bleeding disorder
cancer, type_____	COPD	congestive heart failure
coronary artery disease	diabetes	GERD
glaucoma	hearing loss	heart valve problem
hearts attack or MI	heart problem	hepatitis
high cholesterol	HIV or AIDS	hypertension
kidney disease	liver disease	migraines
Parkinson's	peripheral arterial disease	peripheral neuropathy
prostate problem	psoriasis	Raynaud's
rheumatoid arthritis	seizure disorder	skin cancer
stroke or TIA	thyroid problem	vision problems
other_____	other_____	other_____

Surgeries

Have you had any surgeries? Yes / No (If Yes, please circle all that apply)

appendix	back	bariatric
bladder	bypass legs	bypass heart
cataract	colon	gallbladder
heart valve	kidney	liver
Organ transplant, organ_____	prostate	replacement hip
replacement knee	thyroid	vein stripping
other_____	other_____	other_____

Patient Name:_____

Social and Immunization History

Smoking

Do you currently smoke cigarettes? Yes / No

If yes, how many packs per day do you smoke? Less than 1 / 1 pack / > 1 pack per day

Have you smoked in the past? Yes / No

If yes, when did you quit? This year / 1-5 years ago / More than 5 years ago

Do you drink alcohol regularly? Yes / No

If yes, how much? Socially / 1 drink per week / 1 drink per day / 1 or more per day

Flu & Pneumonia Vaccine

Have you had a flu shot this year? Yes / No

If yes, when,_____

Have you had a pneumonia (pneumococcal pneumonia) vaccine? Yes / No

If yes, when,_____

Have you had a COVID vaccine this year? Yes / No

If yes, when,_____

Podiatric Problem

Can you describe what type of foot, ankle or leg problem you are having?

_____

Which of foot, ankle or leg is the problem on: left / right / both

Where in particular is the problem?_____

When did the problem begin? today / ____days ago / ____ weeks ago / ___months ago/ ___ years ago

Do you remember a particular injury or cause? Yes / No

If yes, explain;_____

Did the problem begin suddenly or gradually

Have you had any prior treatment for this problem? Yes / No

If yes, explain;_____

If painful, how would you describe the pain?: dull sharp aching burning shooting throbbing other,

_____

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Patient Name:_____

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, _____ hereby authorize Complete Foot and Ankle Associates (the practice) to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize the practice to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I request payment from my insurance company or Medicare to be made directly to the practice. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. This authorization may be revoked at any time by me with written notice to the practice. Most insurance plans require that patient authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient can not sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We can not call your doctor to request a referral on your behalf. If you have a co-pay, it is due at the time of the visit. If you fail to pay your copay at the time of the visit, a $5.00 surcharge will be applied for each month until the balance is paid. We do not bill for copay.

Regardless of your insurance plan, you are financially responsible for payment. If the claim we submit is not paid by your insurance plan within 90 days, we consider the claim as "not covered" by your plan, and you will become financially responsible. Should your account go to collection, you agree to pay any and all expenses, including collection fees or percentages.

Acknowledgement of Practices Notice of Privacy Practices
By signing my name below, I acknowledge that I am aware that a copy of the Notice of Privacy Practices (NPP) is available to me (copy located in waiting room) and I have had the opportunity to read, if I so chose, and understand the Notice of Privacy Practices (NPP) and agree to its terms. I may request and receive a printed copy of the NPP upon request.

MEDICARE PATIENTS ONLY: I request that payment of authorized medical and surgical benefits and supplies be made to Complete Foot and Ankle Associates on my behalf or any covered dependents. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS: As a self-paying patient I understand that I am responsible for and will pay for all medical/podiatric services at the time of the visit.

I have read, understand and agree to the above. _____/_____/_____
Today's Date

_____ _____
Patient's Name (Please Print) Patient's Signature

_____ _____
If under 18 years old, Patient's or Guardians Name (Please Print) If under 18 years old, Patient's or Guardians Signature

Designation Of Patient Spokesperson (PHI)

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information: Please Print
Patient Name:_____ Date Of Birth:_____
Address:_____ Phone #:_____

Authorized Individual: Please Print
Name:_____ Relation To Patient:_____
Address:_____ Phone #:_____

I grant to the individual named above to have access to:
_____ All of my PHI

_____ Other- Specify limits or specific health care incident

1. I understand that I may revoke these designations at any time by notifying the appropriate Complete Foot & Ankle Associates in **writing**; however, if I do revoke the authorization, it will not have any effect on any actions taken by Complete Foot & Ankle Associates prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPPA
4. I understand that this authorization will: (Must check one)
   ( ) expire 1 year from the date executed
   OR
   ( ) be effective for the lifetime of the patient unless revoked

Signature of Patient/Personal Representative:_____

Name Of Personal Representative:_____ Date:_____

Relationship to patient:_____

YOU MAY REFUSE TO SIGN THIS FORM