PATIENT REGISTRATION FORM

Today's Date: _____ Referred By: _____

Patient First Name: _____ MI_____ Last Name: _____

Sex: ☐M ☐F Race: (circle one) White Black Hispanic Other: _____

Marital Status: (circle one) Single Married Divorced Widowed Birth Date: _____

S.S. #_____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Patient Employer: _____ Patient Occupation: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip: _____

FINANCIALLY RESPONSIBLE PARTY

Note: If patient is under 18 years of age this information is regarding the parent/legal guardian with the patient today

First Name: _____ MI _____ Last Name: _____

Sex: ☐M ☐F Birth Date:_____ Age: _____

Address: _____ SS #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

INSURANCE POLICY HOLDER INFORMATION

Note: This information is regarding the person who carries the insurance

Full Name: _____ Date of Birth: _____

Address: _____ S.S. # _____

City: _____ State: _____ Zip: _____

Employer Name: _____ Employer Phone _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Comprehensive History Form

Name: _____ **Family Physician:** _____

Family Physician Phone: ( )_____ Date Last Seen: _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Past Medical History:

Ulcers	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No

Other _____

Medications: (List Dose and How Often Taken)
(If you have a current list we will copy it)

1 _____
Dose _____
2 _____
Dose _____
3 _____
Dose _____
4 _____
Dose _____
5 _____
Dose _____

Previous Surgery (s): You may use back of form if necessary

_____

_____

Allergies: _____

Family History:
Does Anyone in Your Family Have a History of any of the following:

			Family Member
High Blood Pressure	❑ Yes	❑ No	_____
Diabetes	❑ Yes	❑ No	_____
Heart Disease	❑ Yes	❑ No	_____
Stroke	❑ Yes	❑ No	_____
Cancer	❑ Yes	❑ No	_____
Thyroid Disease	❑ Yes	❑ No	_____

Is your father: Living or Deceased Cause of Death _____
Is your mother: Living or Deceased Cause of Death _____

Social History:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Do you live alone? ❑ Yes ❑ No

Occupation: _____

Do you smoke? ❑ Yes ❑ No If yes, how much per day _____ How many years? _____

Do you drink alcohol? ❑ Never ❑ Daily ❑ Occasionally ❑ Rarely

Do you exercise? ❑ Never ❑ Rarely ❑ Regularly

Patient Signature: _____ Date: _____

North Central Indiana Podiatry, LLC.

LIFETIME AUTHORIZATION

Insurance assignments and Authorization to Release Information

1) **RELEASE OF INFORMATION** – I, the below named patient, do hereby authorize the physicians of North Central Indiana Podiatry, LLC, to release to my insurance company any medical records concerning my diagnosis and treatment, when requested by the insurance company, for its use in connection with determining payment on a claim.

2) **PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named subscriber, hereby authorize payment directly to the physicians of North Central Indiana Podiatry, LLC, from my insurance company for services rendered.

3) **MEDICARE/MEDICAID** – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under the Title XVIH/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family services or its intermediaries or carriers, any information needed for processing of related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

4) **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE**. *This assignment will remain in effect until revoked by me in writing.*

****Please remember that your insurance benefits are a contract between you and your insurance carrier. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges billed. I understand it is my responsibility to pay any **DEDUCTIBLE AMOUNT, CO-INSURANCE, COPAYS, OR ANY OTHER BALANCE NOT PAID FOR** by my insurance or third payer within a reasonable period of time.****

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

5) I have seen and read a copy of the Notice of Privacy Practices.

6) **CONSENT TO TREAT** – I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies that are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient Name, PRINTED: _____

Patient Signature: _____ Date _____

(If patient is under 18, legal Guardian must sign)