

PERFORMANCE FOOT AND ANKLE CENTERS, LLC

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ADULT PATIENT REGISTRATION FORM

Referred By: Physician: (Name) Patient: (Name) Other: (how)

PATIENT INFORMATION

First Name:	MI:	Last Name:	Marital Status: S M W D Sep
Address:		City:	ST: Zip:
Date of Birth:	Social Security #: _____ - _____ - _____		Gender: M or F Age: _____
Home Phone:		Cell Phone:	Work Phone:

Preferred Method of Contact (Please circle one): Home Phone Cell Phone

Email:	Occupation:
Employer:	Employer Phone:
Employer Address:	City: St: Zip:

SPOUSE/SIGNIFICANT OTHER/EMERGENCY CONTACT

First Name:	MI:	Last Name:	SS # _____ - _____ - _____
Address:		City:	ST: Zip: DOB:
Home Phone:	Cell Phone:	Employer:	Phone:

Do you authorize this office to discuss your care or treatment with any party besides yourself? YES NO

Authorized Persons:

May we leave messages on your phone? YES NO Preferred Contact Phone Home Cell Work

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance:	Identification #	Group #
Policy Holder's Name:	Date of Birth:	Relationship:
Secondary Insurance:	Identification #	Group #
Policy Holder's Name:	Date of Birth:	Relationship:

WORKER'S COMPENSATION INFORMATION

Worker's Comp Carrier:	Date of Injury:	Claim #
Case Manager:	Phone:	Fax:
Address:	City:	ST: Zip:

AUTHORIZATIONS

- I hereby authorize release of medical information for insurance claim purposes and to other healthcare professionals involved in the treatment of care
- I hereby authorize payments of my medical benefits to go to Performance Foot and Ankle Center, LLC
- I understand that I am responsible for any portion of my bill not covered by my insurance company
- I understand that if the account is not paid in full I will be sent to collections.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the notice
- I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed: _____
 Signature of Patient or Authorized Representative

Date: _____
 (Month/Day/Year)

Patient Complaint

Patient Name: _____ Date: _____

What is the reason for today's visit? _____

Location of Problem: _____ How long has this bothered you?: _____

Circle how painful: **Mild Moderate Severe**Circle how often: **Occasionally Daily At Night Walking Running Constantly**

What caused the problem? _____

Was there trauma or any other aggravating factors? _____

Does anything else occur with this problem? YES NO (if yes, please explain) _____

Review of Systems

(please check all that apply)

- Constitutional** Fatigue/Weakness Fever Good General Health
- Eyes** Eye Disease/Retinopathy Eye Inflammation Eye Injury Eye Strain Vision Problems
- Ears, Nose & Throat** Bad Breath/Bad Taste in Mouth Bleeding Gums Dental Problems Ear Discharge
 Ear Noises Hearing Loss Hoarseness Mouth Sores Nose Bleeding
 Nose Discharge Sinus Problems Sore Throat Speech Difficulty
- Cardiovascular** Chest Pain Extremities are Cold Feet/Ankle Swelling Hands Swell Heart Attack
 Heart Problems High Blood Pressure Leg Pain Walking Low Blood Pressure Night Sweats
 Pain Over Heart Rapid Heart Beat Stents in Heart/Legs Varicose Veins Vascular Grafts
- Genitourinary**
(Urogenital) Blood in Urine Difficult Urination Discolored Urine Frequent Urination
 Incontinence or Leakage Kidney Stones Painful Urination Prostate Trouble
- Gastrointestinal** Abdominal Pain Appendicitis Black Stool Bloody Stool Constipation Diarrhea
 Difficult Chewing Difficult Swallowing Excessive Hunger Flatulence Gallbladder Trouble
 Hemorrhoids Indigestion Nausea Poor Appetite Stomach Trouble Ulcers
 Vomiting Food Weight Gain Weight Loss
- Nervous System** Brain Disease Convulsions Dizziness Fainting Forgetfulness Headaches
 Loss of Feeling Muscle Jerking Numbness/Tingling Sensations Paralysis
 Seizure Spine Disease Stroke Weakness
- Respiratory** Allergies Asthma Bronchitis Coughing Blood Coughing Phlegm Difficult Breathing
 Emphysema Lung Problems Persistent Cough Shortness of Breath/Wheezing
- Integument**
(Skin) Abrasions Bruises Deformed Nails Discoloration /Change in Skin Color Eczema
 Hives Itching Moles Psoriasis Skin Cancers skin Rash Ulcerations
- Musculoskeletal**
(Muscles/Skeleton) Arthritis Back Pain Bursitis Difficulty Walking Fractures Joint Implants Joint Pain
 Joint Swelling Lumbago Muscle Pain Sciatica Scoliosis Sprains Stiffness
 Muscle Weakness
- Hematologic/Lymphatic** Anemia Bleeding Disorder Easily Bleeds Easily Bruises Enlarged Glands Jaundice
 Past Transfusion Phlebitis Slow to Heal After Cuts Take Aspirin Take Coumadin
- Psychiatric** Confusion Depression Memory Loss/Alzheimer's Nervousness Sleep Problems
- Endocrine** Change in Hat Size Cold Intolerance Diabetes Dry Skin Excessive Thirst
 Excessive Urination Glandular Problems Heat Intolerance Hormone Problem
 Thyroid Disease

Patient History

Height _____ Weight _____ Shoe Size _____ Occupation _____

Ethnicity (please circle one): **Hispanic/Latino** **Not Hispanic/Latino** **Unknown** **Decline**

Race: American Indian or Alaska Native Other Race
 Asian Unknown
 African American White
 Native Hawaiian or Other Pacific Islander Decline to Answer

Preferred Language: _____

Do you have **diabetes**? YES NO **If yes**, do you take?: Insulin Pills Both insulin and pills
 Have diabetes, but it is controlled through other means

Any past foot/ankle problems? **Yes** **No**
 Bunionectomy Hammertoe Ruptured Arch
 Arthrodesis Toe Amputation Implant Other _____

Do you have any artificial joints? **Yes** **No**
 Hip Elbow Knee Shoulder Other _____

What type of shoes do you normally wear? (please check all that apply)
 Athletic sport shoes Dress shoes Sandals
 Casual footwear with no heel Flip-flops Steel toed boots
 Diabetic shoes High heels Work/hiking shoes

Do you get pedicures? **Yes** **No**
If yes, how often? 1-6 times per year Once Per Month More Than Once a Month

Do you use any type of foot treatments at home? **Yes** **No**
If yes, what kind? _____

Social History

Employment Type: Sits at Job Sits/Stands/Walks Stands at Job Stands and Walks
 Retired/Unemployed Sits and Stands at Job Student Other _____

Do you smoke? **Yes** **No** **Former Smoker** **Never Smoked**
How much do you smoke per day? 1-5 cigarettes per day less than 5 cigarettes per week
 1/2 pack per day 1 pack a day more than one pack a day

Do you use: Chewing Tobacco Cigarettes Cigars
How many years? 1-5 6-10 11-15 16-20 over 20 years

Do you drink alcoholic beverages including wine, beer or hard liquo **Yes** **No**
If yes, alcohol quantity is: Rarely 1-2 per week 1-2 per day 3 or more per day

Do you use illicit drugs? **Yes** **No**
If yes, which ones? Cocaine Heroin Marijuana Methamphetamine

Are you currently Pregnant? **Yes** **No** If yes: 1st (1-3 months) 2nd (4-6 months) 3rd (7-9 months)

Marital Status? Married Separated Divorced Single Widowed Have a domestic partner

Do you have children? **Yes** **No** If yes, how many? _____

Current living situation? Live alone Live w/family Live w/Spouse in your own home Skilled Nursing Home
 Retirement community Assisted Living Community Shelter Home for the Disabled Homeless

Do you have stairs in your home? **Yes** **No** If yes, how mar 1-4 1-10 More than 10

Do you exercise? **Yes** **No** If yes, how many times per week? 1-2 3-4 5-6 7 days a week

Patient/Family History

Please check ALL illnesses or conditions that apply to you or your family:

<u>Me</u>	<u>Family</u>		<u>Me</u>	<u>Family</u>	
<input type="checkbox"/>	<input type="checkbox"/>	No Known Medical History	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Aids/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Lymphedema
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems/Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>	PAD/Peripheral Vascular Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	DVT/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Vascular or Bypass Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Goiter/Thyroid			

Surgeries

Have you had any previous surgeries?

If YES please list below:

Allergies

No known allergies Tape

Anesthetics Other (please list below)

Codeine _____

Iodine _____

Latex _____

Narcotics _____

Penicillin _____

Sulfa _____

Medication and Dosage

No Medication at this time

Pharmacy Information

Pharmacy Name _____

Address _____

City, State, Zip _____

Phone Number _____

Fax Number _____

Primary Care Physician

Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

use back of this form if more room is needed

FINANCIAL POLICY OF PERFORMANCE FOOT AND ANKLE

Thank you for choosing Performance Foot and Ankle as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. It is your responsibility to know if we are a participating provider in your health plan. If you are not insured by a plan we participate in or your insurance is not active at the time of service, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Prior to providing new service, unpaid balances must be paid or payment arrangements must be approved by the office manager.

Non-covered services. Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your service.

Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or state ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information you will be responsible for the balance of the claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. A patient presenting to our office without a valid referral will be asked to pay in full.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate charges to help you receive your maximum benefits.

Non payment. Statements are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. Partial payments will not be accepted unless otherwise approved by the office manager. If the account is not paid in full by 91 days, the account will be charged a late fee and the account will be sent to a collection recovery program. Please be aware that if a balance remains unpaid you will receive notice of the pending collections process. At that time we will refer your account to a collections agency or small claims court and you and your family members may be discharged from the practice. Once your account has been placed into the collection process you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. Our policy is to charge \$25.00 for missed appointments not cancelled within 24 hours prior to the appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. More than 3 no-show appointments may result in termination of care for non-compliance.

Refunds. Overpayments will be refunded to the appropriate party. Patient refunds will not be provided until all active and past due accounts are paid in full. Patient credits under \$35.00 will be reinstated upon patient's return unless specifically requested.

Fees. Our fees are representative of the usual and customary charges for our area. An additional fee of \$25.00 will be added for each returned check claiming non sufficient funds.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party

Date