

Initial Comprehensive Patient Registration

TODAY'S DATE _____

PATIENT INFORMATION

PATIENT'S LAST

NAME _____ FIRST _____ MIDDLE _____

INITIAL _____

MAILING ADDRESS _____ APT _____

NO _____

CITY _____ STATE _____ ZIP _____

CODE _____

HOME PHONE _____ CELL PHONE _____

PATIENT E-MAIL _____

ADDRESS _____

SEX: _____ M _____ F AGE _____ DATE OF

BIRTH _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

SS# _____ MARITAL STATUS:

_____ Single _____ Married _____ Widowed _____ Separated _____ Divorced

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER _____

PHONE _____

SPOUSE'S

NAME _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS A

MINOR) _____

PARENT/GUARDIAN SS# _____

PARENT/GUARDIAN DATE OF BIRTH _____

REFERRAL INFORMATION – HOW DID YOU FIND OUT ABOUT US?

_____ FAMILY MEMBER / FRIEND

_____ NEWSPAPER

_____ DR. _____

_____ TV/RADIO AD

_____ INSURANCE BOOK

_____ HOSPITAL

_____ PHONE BOOK/YELLOW PAGES

_____ BUILDING SIGN

_____ INTERNET/WEB SITE

_____ OTHER _____

INSURANCE **PLEASE PRESENT YOUR INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST.

INSURANCE COMPANY NAME _____

GROUP NUMBER _____

LAST NAME OF INSURED _____ FIRST NAME _____

MIDDLE INITIAL _____

RELATIONSHIP TO

PATIENT _____

INSURED'S SS# _____ INSURED'S DATE OF BIRTH _____

INSURED'S EMPLOYER _____

EMPLOYER PHONE # _____

REASON FOR VISIT What is the chief complaint for which you came to be treated?

Duration of Problem _____ Have you had previous treatments? _ Yes _ No By Whom? _____

Is this a work related injury? _ Yes _ No What is the date of the injury? _____

How much pain do you have? (Please circle one)

1 2 3 4 5 6 7 8 9 10
No pain Hurts a little Hurts a little more Hurt even more Hurts a whole lot Hurts worst

• **Frequency:** How often do you have your pain? (check one)

- Constantly (100% of the time)
- Intermittently (30-60% of the time)
- Occasionally (less than 30% of the time)
- Nearly constantly (60-95% of the time)

In general, during the past month, when has your pain/problem been the worst? (check one)

Morning Afternoon Early Evening Night No typical pattern

• **Symptom quality:** How would you describe your pain? (Check all that apply and circle the dominant quality)

- Burning
- Sharp
- Cutting
- Throbbing

- Electric
- Cramping
- Dull/aching
- Pressure-like
- Shooting

- Pins and needles
- Walking on a pebble
- Pain on first step of day
- Other (describe)

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• **Relieving and aggravating factors:** How does the following affect your pain? (circle one for each activity)

Activity	Decrease	No Change	Increase
Standing	Decrease	No Change	Increase
Sitting	Decrease	No Change	Increase
Waking	Decrease	No Change	Increase
Exercise	Decrease	No Change	Increase
Elevation	Decrease	No Change	Increase

Check all that apply.

Aggravated by: Weather ____ Shoe ____ Touch ____
Relieved by: Heat ____ Cold ____ Rest ____ Meds ____
Ace or compressive wrap ____

Activities and your pain:

How many blocks can you walk? Less than a block or How many blocks?_____

To assist walking, I use a: Cane Walker Wheelchair No assistance device

Are you **NOT** able to perform any of the following activities of daily living? (Circle all that apply)

Going to work Performing household chores Doing yard work or shopping
Wearing shoes Participating in recreational activities Exercising

Where did the injury occur?_____

If the injury occurred at work, has your employer been notified? _ Yes _ No

Employer_____ Occupation_____ Address_____

City_____ State_____ Zip Code_____

Employer Phone #_____ Contact Person_____

MEDICAL HISTORY – Please indicate foot problems you now have or have had in the past.

Ankle Pain _ Yes _ No

Heel Pain _ Yes _ No

Athlete’s Foot _ Yes _ No

Ingrown Toenails _ Yes _ No

Bunions _ Yes _ No

Plantar’s Warts _ Yes _ No

Corns & Calluses _ Yes _ No

Swelling in Ankle or Feet _ Yes _ No

Flat Feet _ Yes _ No

Foot or Leg Cramps _ Yes _ No

Athletic activities in which you participate (please list and indicate frequency)_____

Please list any surgeries:

Surgery_____ Date_____

Surgery_____ Date_____

Hospitalizations other than for surgeries listed_____

Family Physician_____ Date of last visit_____

Address_____ Phone #_____

Are you now, or have you been, under any other doctor’s care for any reason over the past two years? _ Yes _ No

Substance abuse:

Have you ever been a smoker? Yes-Current Yes In-past No-Never

If you smoke, how many packs per day? _____ Packs per day

For how many years did you smoke? _____ Years

Do you have a history of alcoholism? Yes No Current problem

Have you abused prescription analgesics? Yes No Current problem

Cocaine or intravenous substance abuse? Yes No Current problem

How many years has it been since you abused alcohol or drugs? _____ Years

Review of Systems: Please circle yes or no if you have any of the following problems:**Ears/Nose/Throat/Mouth**

Hearing loss or ringing Yes No

Sinus Problems Yes No

Nose Bleeds Yes No

Sore throat/ voice change Yes No

Gastrointestinal

Nausea/ vomiting Yes No

Abdominal pain Yes No

Rectal bleeding Yes No

Bowel problems Yes No

Respiratory

Shortness of breathe Yes No

Cough Yes No

Wheezing/ asthma Yes No

Coughing up blood Yes No

Neurological

Frequent headaches Yes No

Paralysis or tremors Yes No

Convulsions/ seizures Yes No

Numbness/ tingling Yes No

Allergic/ Immunologic

Food allergies Yes No

Aspirin allergies Yes No

Antibiotic allergies Yes No

Hematologic/ Lymphatic

Bruise easily Yes No

Slow to heal Yes No

Enlarged glands Yes No

Genitourinary – Female Only

Blood in Urine Yes No

Kidney stones Yes No

Sexual problems Yes No

Menstrual problems Yes No

Other

Constitutional

Good general health Yes No
Recent Weight changes Yes No
Night sweats, Fevers Yes No
Fatigue Yes No

Eyes

Wear glasses/ contacts Yes No
Blurred/ double vision Yes No
Eye disease or injury Yes No
Glaucoma Yes No

Cardiovascular

Chest pain Yes No
Palpitations Yes No
Heart Trouble Yes No
Swelling hands/feet Yes No

Musculoskeletal

Muscle pain or cramps Yes No
Stiffness/swelling joints Yes No
Joint pain Yes No
Trouble walking Yes No

Integumentary (Skin/Breast)

Change in hair or nails Yes No
Rashes or itching Yes No
Breast lump Yes No
Breast pain or discharge Yes No

Endocrine

Excessive thirst/urination Yes No
Thyroid disease Yes No
Hormone problem Yes No

Genitourinary – Male Only

Blood in Urine Yes No
Kidney stones Yes No
Sexual problems Yes No
Testicle pain Yes No

Psychiatric

Insomnia Yes No
Confusion/ Memory loss Yes No
Depression Yes No

MEDICATIONS – Include prescriptions, over-the-counter medications, and vitamins:

Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____

Do you take oral contraceptives? _ Yes _ No

Preferred Pharmacy Name _____ Pharmacy Phone _____

ALLERGIES – Mark any that apply:

- No Known Allergies _
- Adhesive Tape _ Yes _ No
- Latex _ Yes _ No
- Anti-Inflammatory Meds _ Yes _ No
- Local Anesthetics _ Yes _ No
- Anticoagulant Therapy _ Yes _ No
- Novocain _ Yes _ No
- Aspirin _ Yes _ No
- Penicillin _ Yes _ No
- Codeine _ Yes _ No
- (Iodine) Seafood _ Yes _ No
- Cortisone _ Yes _ No
- Sulfa Drugs _ Yes _ No
- Demerol _ Yes _ No
- Eggs _ Yes _ No
- Peanuts _ Yes _ No
- NSAIDS _ Yes _ No
- Morphine _ Yes _ No
- Ampicillin _ Yes _ No
- Glove Powder _ Yes _ No
- Other _____

SIGNATURE & AUTHORIZATION TO PERFORM SERVICES

I request that payments of authorized benefits on my behalf for any services furnished me by Richmond Foot and Ankle Clinic, LLC I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any coinsurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Richmond Foot and Ankle Clinic, LLC. to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Signed _____ Date _____

FINANCIAL POLICY

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. **To ensure quality communication, it is the patient’s (and/or guardian’s) responsibility to inquire about fees/insurance coverage prior to any service being performed.** We accept many different insurance plans, however all plans are not the same and do not cover the same services.

• Managed Care Patients/Private Insurance

If you are in a managed care plan (HMO, PPO, IPA) with which we participate, we abide by our contract with them. I neither managed care plans or private plans, we will bill your insurance company; however you are responsible for paying any Co-Pays, coinsurance and deductibles required by your plan at the time of treatment.

• Medicare Patients

We accept assignment for Medicare: that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

• Uninsured Patients

A sliding fee will be charged based on income and is due at the time of service.

• **All Patients**

For your convenience, we accept Visa, MasterCard, Discover, cash, or check. There is a \$25 service fee for all returned checks

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Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Richmond Foot and ankle Clinic, LLC

Patient or Authorized Representative's Initials Date

DURABLE MEDICAL EQUIPMENT POLICY

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Richmond Foot and Ankle Clinic, LLC is **not** responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. *Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.*

My initials below represent that I have read, understand, and accept this policy.

Patient or Authorized Representative's Initials Date

PRIVACY STATEMENT

Richmond Foot and Ankle clinic, LLC will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operation activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY _ YES _ NO

SPOUSE ONLY _ YES _ NO

OTHER (PLEASE SPECIFY) _____ _ YES _ NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the notice.

Patient or Authorized Representative's Initials Date