# 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_____Seperated_____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)



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

| **Activity** | | | |
|---|---|---|---|
| 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 |

**Integumetary (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 perfomed.** 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