CarePlus
Foot & Ankle Specialists

New Patient Registration Form

PATIENT INFORMATION

Patient's Name _____
First *Middle* *Last*

Date of Birth _____ / _____ / _____ Sex ☐ Male ☐ Female

Ethnicity ☐ Hispanic ☐ Non-Hispanic Race ☐ African American ☐ Asian ☐ Caucasian ☐ Other

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email (for appointment reminders) _____

Employer's Name _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____
☐ Google ☐ Bing ☐ Yelp ☐ Insurance Website ☐ Other Internet Search

INSURANCE POLICY HOLDER INFORMATION *(If the patient is the policy holder, you may skip this section.)*

Relationship of Patient to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name _____
First *Middle* *Last*

Date of Birth _____ / _____ / _____ Sex ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer's Name _____

INSURANCE INFORMATION *(Please allow the receptionist to photocopy your insurance cards.)*

Primary Insurance _____

Policy # _____ Group # _____ Phone _____

Secondary Insurance _____

Policy # _____ Group # _____ Phone _____

The above information is true to the best of my knowledge.

_____ _____
Patient/Guardian Signature *Date*

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Patient Health Form

Patient's Name _____ Height _____ Weight _____

Primary Doctor's Name _____ Date of last Primary visit _____

PRESENT CONDITION

What is your foot or ankle condition?_____

_____

How long have you had this?_____ What is your level of pain (0-10)? _____

Have you tried any treatments?_____

ALLERGIES ☐ No known drug allergies

☐ Tape ☐ Codeine ☐ Cortisone ☐ Shellfish ☐ Latex

☐ Sulfa ☐ Penicillin ☐ Novocaine/Local Anesthetics ☐ Other _____

MEDICATIONS ☐ None

List prescriptions, over-the-counter medications, and vitamins _____

_____

_____

HISTORY

Do you or anyone in your immediate family have any of the following conditions?

	Yes	No	Family		Yes	No	Family
Arthritis	☐	☐	☐	High Blood Pressure	☐	☐	☐
Bleeding Disorders	☐	☐	☐	High Cholesterol	☐	☐	☐
Blood Clots (DVT)	☐	☐	☐	HIV/AIDS	☐	☐	☐
Cancer _____	☐	☐	☐	Kidney Disease	☐	☐	☐
Circulatory Disorders	☐	☐	☐	Liver Disease	☐	☐	☐
Coumadin Therapy	☐	☐	☐	Low back pain	☐	☐	☐
Diabetes Type _____	☐	☐	☐	Reflux (GERD)	☐	☐	☐
Dialysis	☐	☐	☐	Respiratory Disorders	☐	☐	☐
Glaucoma	☐	☐	☐	Sciatica	☐	☐	☐
Gout	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Disorders	☐	☐	☐
Hepatitis Type _____	☐	☐	☐	Other _____	☐	☐	☐

Do you have numbness in your feet? ☐ Yes ☐ No Do you get leg cramps when you walk? ☐ Yes ☐ No

List previous surgeries with approximate dates _____

_____

Do you smoke? ☐ Yes ☐ No ☐ Previously Packs per day _____ How many years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks _____ per ☐ day ☐ week ☐ month

Current or previous illicit drug use? ☐ Yes ☐ No _____

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature *Date*

Office and Financial Policies

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize direct payment of my insurance benefits to CarePlus Foot and Ankle Specialists or the physician individually for services rendered to my dependents or me by the physician or under his supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be financially responsible for any copay or balance due that CarePlus Foot and Ankle Specialists is unable to collect from my insurance carrier for whatever reason.

MEDICARE AND INSURANCE BENEFITS
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to CarePlus Foot and Ankle Specialists or the physician on my behalf.

PAYMENT
Payment for foot care products and services including copays are due at the time of service. We accept cash, checks, VISA, MasterCard, American Express, and Discover. There is a service fee of $25.00 for all returned checks. Failure to pay on accounts over 90 days will result in the account being turned over to collections and incurring additional fees.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION
I hereby authorize CarePlus Foot and Ankle Specialists or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL / CALL / EMAIL
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a CarePlus Foot and Ankle Specialists representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying CarePlus Foot and Ankle Specialists to that effect in writing.

LAB / X-RAY / DIAGNOSTIC SERVICES
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

APPOINTMENTS
In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hour notice may result in a fee of $25.00. You might be asked to pay before you are seen by the doctor. Patients who come to the office more than fifteen minutes later than scheduled may be asked to reschedule.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)
I understand that the HIPPA Notice of Privacy Practices is available at my physician's office and on the CarePlus Foot and Ankle Specialists website bellevuefootdoctor.com. I acknowledge that I have read (or had the opportunity to read) and understood the notice.

CONSENT TO TREATMENT
I hereby consent to evaluation, testing, and treatment as directed by my CarePlus Foot and Ankle Specialists physician or his designee.

_____ _____

Patient/Guardian Signature *Date*