



New Patient Registration Form

PATIENT INFORMATION

Patient's Name _____
First Middle Last

Date of Birth ____ / ____ / ____ Sex Male Female

Ethnicity/Race Asian Black or African American Hispanic or Latino White Other

Mobile Phone _____ Home Phone _____

Address _____ Apt _____

City _____ State _____ Zip _____

Email _____

Employer's Name _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

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

Primary Insurance _____

Policy # _____ Group # _____ Phone _____

Secondary Insurance _____

Policy # _____ Group # _____ Phone _____

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 _____

Patient's Name _____
First Middle Last

Date of Birth ____ / ____ / ____ Sex Male Female

Address _____ Apt _____

City _____ State _____ Zip _____

Mobile Phone _____ Home Phone _____

Employer's Name _____

The above information is true to the best of my knowledge. *Patient/Guardian Initials* _____



Patient Health Form

Patient's Name _____ Height _____ Weight _____

Primary Doctor's Name _____ Date of Last Primary Visit _____

PRESENT CONDITION

What is the reason for your visit? Right Left Both

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

Have you tried any treatments? _____

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

ALLERGIES

No Known Drug Allergies
 Tape Codeine Cortisone Shellfish Latex
 Sulfa Penicillin Lidocaine/Anesthetics Other _____

MEDICATIONS

None
List prescriptions, over-the-counter medications, and vitamins _____

MEDICAL HISTORY

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

	Self	Family	None		Self	Family	None
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

The above information is true to the best of my knowledge. *Patient/Guardian Initials* _____



Office and Financial Policies

APPOINTMENTS

In fairness to our patients, we understand that emergencies occur but repeated no shows or cancellations with less than 24-hours notice may result in a fee of \$50.00. You may 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.

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 the services I am to receive are a covered benefit. I understand and agree that I will be financially responsible for any co-pay 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 co-pays are due at the time of service. We accept cash, checks, debit, VISA, MasterCard, and American Express. There is a service fee of \$50.00 for all returned checks. Failure to pay on accounts over 90 days may result in the account being turned over to collections and incurring additional fees.

LAB / IMAGING STUDIES / DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes lab, imaging studies, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

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 non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL / CALL / TEXT / EMAIL

I certify that I understand the privacy risks of mail, phone calls, text messages, and email. I hereby authorize a CarePlus Foot and Ankle Specialists representative or my physician to mail, call, text message, 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.

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.

Patient/Guardian Signature

Date