PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: ____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking	☐fever	☐ chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐valve problems	☐**NONE**
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool	☐vomiting	☐ulcers ☐constipation
	☐diarrhea	☐trouble swallowing	☐decrease appetite	☐increase appetite	☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin ☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders ☐**NONE**
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			☐**NONE**
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis ☐**NONE**
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Robert T. Spalding, DPM
1225 Taft Highway
Signal Mountain, TN 37377

Due to HIPPA (Privacy Act) we are requesting that the patient please complete this information sheet prior to being seen by Dr. Spalding or his associates at Area Podiatry Center. Please check the appropriate box.

1. I ( ) do ( ) do not authorize a message to be left either on an answering machine or with whomever may answer the phone.

2. I ( )do ( ) do not authorize release of medical information to outside sources such as insurance carriers, home health agencies, and worker's compensation plans. Please list the name of your insurance company, home health agency and worker's compensation plan.

3. I ( ) do ( ) do not authorize release of medical information to any laboratory or facility for which diagnostic tests are requested by my physician.

4. I ( )do ( ) do not authorize release of prescription information to my pharmacy.

5. I ( )do ( ) do not authorize release of medical information to my designated caregiver. This includes the person who may pick up any prescription or order information Please list the person and the relationship to me.

   _____

6. I ( ) do ( ) do not authorize release of medical information for any orthotic or shoe information for gear initiated by Dr. Spalding.

7. I ( ) do ( ) do not authorize acquiring pictures and the release of pictures of my foot pathology to be used between physicians, in educational settings, seminars, books or other printed material to increase the knowledge base of this profession, related professions ro general public and I do not seek compensation for such allowance.

I, _____, being the patient above have completed the above and checked the appropriate boxes and completed the appropriate information. I fully understand that this guideline will be strictly enforced. I am fully aware that if any information needs to be changed that I will need to complete a new form. Furthermore, I must designate a pharmacy to have an option of prescription call ins. I realize that if I have not designated a specific person to pick up my medical information then records cannot be given to any family member. I fully realize that if I do not authorize pictures of my feet, Dr. Spalding will be unable to document my foot pathology and Dr. Spalding reserves the right to not treat me for his protection. Finally, I acknowledge that I do not wish for information to be released to insurance companies and the worker's compensation plan that I will be personally responsible for the amount due.

_____ _____

OUR FINANCIAL POLICY

Thank you for choosing us as your foot care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

(This includes your co-pays, deductibles, insurance percentages and assignment of insurance payments.) **There will be a $5.00 charge for re-billing on any patient balance over 30 days delinquent. Any balance that is not paid in full after 30 days will be charged an extra 1.5% interest per month. You will be billed a minimum office charge for any scheduled visit not canceled 24 hours prior to service. Any bill over 90 days from date of service may be sent to collections. You are then responsible for an additional 35% collection fee charge plus any attorney fees. You may be ask to sign a credit cards slip to guarantee medical service payments if we have reason to believe an insurance carrier may not pay for services or if self pay.**

REGARDING INSURANCE

We may accept assignment of insurance benefits however, be aware that the charges, whether your insurance company pays or not, is your responsibility. We cannot bill your insurance unless you give us your insurance information. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **WE ARE NOT PARTY TO THAT CONTRACT.** If your insurance company has not paid your account in full within 90 days, the balance will automatically become your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and verify the accuracy of the information given. I assign insurance benefits directly to Dr. Robert Spalding, if any, otherwise payable to me for services rendered. I will allow verbal/written/faxed reports about my appointments or health records to be left on my answering machine or with a family member. I understand that I am financially responsible for all charges whether or not paid by insurance. I additionally understand Medicare or other insurance may not cover some podiatric services and I will be responsible for any non-covered services. I hereby authorize the doctor to release all necessary information to secure payment of benefits and authorize use of this signature on all insurance submissions. I am aware that if my account goes to collections, I am responsible for a 35% additional collection fee and/or legal fees.

_____ _____

Authorized Signature *Date*