Bay Area Foot Care
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ MI ____

Date of Birth _____

SSN _____

Address _____

City _____

State _____Zip_____

Telephone (_____) _____

E-mail:_____

Primary Physician_____

Phone# _____

Referring Physician_____

Phone#_____

☐ **Male** ☐ **Female**

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

☐ **White** ☐ **American Indian / Alaska Native** ☐ **Asian**

☐ **Black or African American** ☐ **Native Hawaiian**

☐ **Hispanic Latino** ☐ **Other** ☐ **Veteran**

Occupation _____

Employer _____

Address_____

_____

Check Preferred Method

☐ Work Phone (____) _____Ext_____

☐ Cell Phone (____) _____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse

PHARMACY INFORMATION

Pharmacy Name_____

Phone#: _____Fax#:_____

Address_____

City_____ State_____

Zip_____

EMERGENCY CONTACT (If other than Spouse)

Name_____

Relationship: _____

Telephone (____) _____

Guarantor Information: Complete if different from Patient

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____) _____

DOB _____/_____/_____

Employer_____

Address_____

Work Phone (____) _____Ext_____

PATIENT NAME_____ DATE OF BIRTH _____/_____/_____

Is your treatment today due to:

……..a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated Yes ☐ No ☐

……..a motor vehicle accident ☐ Yes ☐ No Accident Date_____

……a an accident/ liability case ☐ Yes ☐ No Accident Date_____

Whom may we thank for sending you to our office?

☐ Doctor_____

☐ Patient_____

☐ Newspaper_____

☐ Other_____

☐ Verizon Yellow Pages

☐ The Yellow Book

☐ Insurance Provider List

☐ Passed by Location ☐ Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing.

I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X_____ Date _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits and if applicable Medigap benefits, be made either to me or on my behalf to **Bay Area Foot Care, Inc.** for any services furnished to me by the listed provider/supplier. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)		**PROVIDER: Name, Address, and Zip**
PATIENT'S SIGNATURE		
PATIENT'S MEDICARE NO.	DATE	

PATIENT NAME _____ DATE _____/_____/_____

Referring Physician Name: _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **When did pain/discomfort begin (date):** _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ No ☐ Yes _____

5. **Have you had an accident?** ☐ No ☐ Yes _____

6. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No

7. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: _____

8. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

9. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

10. **Are you currently pregnant?** ☐ No ☐ Yes _____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

12. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____
☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
☐ Other family History: _____

14. **Height: _____** 15. **Weight: _____** 16. **Shoe size: _____**

Bay Area Foot Care
PATIENT REGISTRATION FORM

PATIENT NAME _____DATE _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature