Patient Registration Form

Date of Appointment: _____

Patient Information

First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (mm/dd/yyyy)

Address	City	State	Zip

Primary Phone	Secondary Phone	Email

Referred by	Primary Care Physician	Date of Last Visit with Primary Care Physician

Patient Employer/School Information

Employer/School	Occupation

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Reason for Visit

What brings you to our office today?

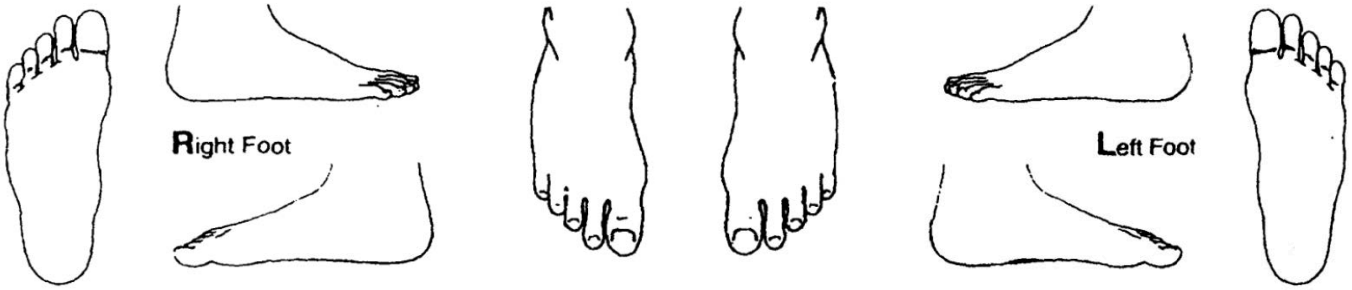
When did your pain start? When is the date of the injury?

Please describe any previous treatment you have received for this problem.

How severe is your pain? 1=minimal 10=severe

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mark all the problem areas with the letter 'X'.



Medical History

Major Injuries ☐ NONE

Injury _____ Date _____

Injury _____ Date _____

Surgeries/Hospitalizations ☐ NONE

Procedure/Reason for Hospitalization _____ Date _____

Procedure/Reason for Hospitalization _____ Date _____

Past Medical History ☐ NONE

☐ Cancer ☐ Gout ☐ Osteoporosis ☐ Other: _____

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Vascular Disease _____

Family History ☐ NONE

☐ Cancer ☐ Gout ☐ Osteoporosis ☐ Other: _____

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Vascular Disease _____

Social History

Tobacco Use ☐ Yes ☐ No How many packs/day? _____ How long? _____

Alcohol Use ☐ Yes ☐ No How many drinks/week? _____

Current Medications ☐ NONE

Medication _____ Dosage _____ Directions _____ Reason for prescription _____

Medication _____ Dosage _____ Directions _____ Reason for prescription _____

Allergies ☐ NONE

☐ Penicillin ☐ Codeine ☐ Adhesive Tape ☐ Local Anesthetic ☐ Other: _____

☐ Sulfa ☐ Aspirin ☐ Iodine _____

Reaction: _____

Review of Symptoms (Please Circle Options) ☐ NONE

Health in General: Lack of energy, unexplained weight gain or loss, loss of appetite, fever, night sweats

Resp. (Lung & Breathing): Shortness of breath, prolonged cough, wheezing, sputum production

Integ. (Skin & Hair): Persistent rash, itching, new skin lesion, change in existing skin lesion, open wound, hair loss or increase

Neurologic (Brain & Nerves): Headaches, vision changes, weakness, problems with walking or balance, dizziness, tremor, loss of consciousness, numbness or tingling

C-V (Heart & Blood Vessels): Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking

GI (Stomach & Intestines): Heartburn, constipation, diarrhea, abdominal pain, nausea, vomiting, blood in stools

MS (Muscles, Bones, Joints): Joint pain, aching muscles, swelling of joints, deformities, back pain

Other: _____

Elevate
Podiatry

AUTHORIZATION FORM

Please read the following information carefully and sign at the bottom of the page to give consent.

Authorization for Treatment and Release of Protected Health Information

- I authorize the release of medical information to Elevate Podiatry and all providers under contract with Elevate Podiatry.
- I authorize Elevate Podiatry to treat and perform procedures that may be necessary as deemed by the treating provider.
- I authorize the release of medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse - to include alcohol & drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Elevate Podiatry.

Notice of Privacy Practices Acknowledgment

- Notice of Privacy Practices provides information about how Elevate Podiatry may use and disclose protected health information about our patients. By signing this form you have acknowledged the receipt and opportunity to read the notice of privacy practices of Elevate Podiatry. You may access a copy of the notice at our office or by visiting our website at www.elevatefoot.com
- You have the right to request restrictions on how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
- By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice.

Patient Financial Policy

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service.
- In the event your health insurance determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all changes in insurance and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____ **Date:** _____

Print Name of Patient/Responsible Party: _____