Date_____ Acct. #_____

Patient Registration

Please print it out and once you complete the form send it back via email to manager@nationalfootcenters.com

Last Name _____First Name _____MI ____

Street _____Apt # ____City _____ State___Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____ext ____

Date of Birth ___/ ____/ ____ Age ____ Sex _____ Marital Status S__ M__ W__ D__ Other __

Occupation _____ Employer_____ Retired___

Race: Caucasian ___African American___ Other ___ _____ Non Hispanic __ Hispanic ___ Dominant Hand: R__ L__

Preferred Language _____ Preferred Mode of Communication Phone__ Cell__ Mail __ E-Mail__

E-Mail Address _____Local Pharmacy and Location_____

Emergency Contact_____Phone _____Relationship_____

Primary Care Physician _____City/Town_____

Who may we thank for referring you? _____

Primary Insurance_____

ID # _____ Group # _____

Subscriber Name_____Birth date _____

Patient Relationship Self___ Spouse___ Child ___ Other___

Secondary Insurance_____

ID# _____Group # _____

Subscriber Name _____Birth date _____

Patient Relationship Self ___ Spouse ___ Child ___ Other___

Reason for today's visit _____

Family History (Blood Relatives) – Please check all that apply

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis						
Bleeding Disorder						
Bunions						
Circulatory Problems						
Diabetes						
Flat Feet						
Hammertoes						
Heart Disease						
Neurologic Disorders						
Stroke						

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Name_____ Patient Acct, #_____

Height_____**Weight**_____**Typical Blood Pressure** _____/_____ **Shoe Size**_____

Please check if any of these are applicable to you:

___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Circulatory Disease
___ Connective Tissue Disorder
___ COPD
___ Diabetes Insulin Y__ N __
___ Gout
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Neurological Disorder
___ Rheumatoid Disorder
___Stomach Ulcers
___Thyroid Disorder
___**Other** _____

___ **NONE of the above conditions apply**

Allergies (check or note all that apply to you)

___ Antibiotics _____
___ Aspirin
___ Betadine (Iodine)
___ Codeine
___ Ibuprofen (Advil, Motrin)
___ Latex
___ Local anesthetics (Novocaine, Lidocaine)
___ Penicillin
___ Seafood
___ Sulfa
___ Other _____

Medications and dosages (including non prescription or herbal supplements)

_____
_____
_____
_____
_____

See my list____ **No Medications____**

___ **No known drug allergies**

Do you smoke? Y__ N__ # of packs per day ____ Are you a previous smoker? Y__ N__ # of packs per day ___
Do you drink alcohol? Y___ N___
Have you had any major surgeries in the last 5 years? Y___ N___ If yes, what type_____

Do you have any artificial joints Y ___N ___ Location _____ Do you have a heart valve implant? Y ___ N___

Is there anything you wish to tell the doctor privately? Y___ N___

____**(Initials)** I request that payment of the authorized benefits be paid either to me, or to National Foot Centers on my behalf, for all services rendered to me by the doctor. I authorize any holder of medical information about me to release to my insurance company and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services.

____**(Initials)** I hereby give permission to have my feet examined and treated. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any change in my health status, or in any of the above information, which is true to the best of my knowledge.

____**(Initials)** I have received a copy of the Summary of Notice of Privacy Practices which National Foot Centers follows as mandated by HIPAA (Health Insurance Portability and Accountability Act).

_____ _____

Patient (or representative) Signature **Date** **Doctor Signature** **Date**

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Summary of Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information electronically;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices**.**
  A copy of the complete Notice is available upon request.

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NATIONAL FOOT CENTERS

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Health Problems _____

Primary Doctor _____ **Doctor's Phone** _____

Local Pharmacy _____ **Pharmacy Phone** _____

Drug Allergies _____ **Your Phone** _____

Your Name _____ **Date** _____

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NATIONAL FOOT CENTERS

Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient

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