Patient Registration Form

.

Patient Information (PLEASE complete all applicable spaces)

Full First Name: ______________________________ MI: _______ Last Name: ____

Primary Address: ____City: _____________________ State: ______ Zip: ________

Home Phone: ___________________________________ Alternate (Northern) Home Phone: ______________________________________

Work Phone: ______________________________________ Mobile Phone: ____

Alternate (Northern) Address: _____________________________________City: _____________________ State: ______ Zip: ________

Best time: _______ (AM/PM) & place to reach you: Home/ Work/ Cell/ Email. E-Mail Address: ____________________________________

Age: ______ Birth Date: ______________ Gender: M/F Social Security #: _________________________ Marital Status: ____________

Employer Name/Address: ____ or Student: Yes/No

How did you primarily hear about us: Friend Referring Dr Internet Insurance Newspaper Magazine Phone Book?

Chief Complaint: _____________ Occurrence Date: ____________ Related to: Work:*Yes/No Auto:*Yes/No Accident: *Yes/No

Full Name of Family Doctor: __________________________________ Date last seen: _____________ Phone: _______________________

Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: ____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: ______________________ Claims address: ____

Primary Insured's Full Name: ______________________________ Date of Birth: __________ Gender: M/F SS #: ___________________

Primary Insured's home address: ____

Secondary Insurance

Insurance Name: ____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: _____________________ Claims address: ____

Primary Insured's Full Name: ______________________________ Date of Birth: __________Gender: M/F SS #: __________________

Primary Insured's home address: ____

Medical History

Weight: _____________ Height: ______________ Shoe Size: _____________

Family Doctor: ____ Last Seen: __________________

Related to: Work: Yes/ No/ Auto: Yes/ No/ Accident: Yes/ No/ Illness: Yes/ No/ Are you pregnant? Yes/ No/ Maybe

Smoking: Packs/day: _____Years: _____ Past Smoker: Packs/day _____Years: _____Employment requires you to: Sit/Stand/Walk/Not Employed

Caffeine: Quantity _________ Alcohol: None/Rarely/Moderately/Daily/Quit Recreational Drug Use: None/Rarely/Moderately/Daily/Quit

List Athletic activities: ____ Amount per day/week: _________________

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.______________________

____

____

How long have you had pain? ___ Weeks ___ Months ___ Years - On a scale of 1-10 how bad is the pain? 1 2 3 4 5 6 7 8 9 10

Minimal Severe

Who referred you to us? ____

History Of : Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Liver Disease	Sinus Problems
Anemia	Chest Pain	Flat Feet	Low Blood Pressure	Special Diet
Angina	Chemical Dependency	Gout	Lung Disease	Sports Related Injuries
Ankle Pain	Cancer	Headaches	Nervous Problems	Stomach Ulcers
Arthritis	Circulatory Problems	Heart Disease	Osteoporosis	Stroke
Artificial Heart Valves	Corns and Calluses	Heel Pain	Phlebitis	Swelling in Ankles/Feet
Artificial Joints	Depression	Hemophilia	Plantar Warts	Tired Feet
Asthma	Diabetes	Hepatitis	Polio	Thyroid Disorder
Athlete's Foot	Ear Problems	High Blood Pressure	Radiation Treatment	Tuberculosis
Back Problems	Eptlepsy	Ingrown Toenails	Rash	Varicose Veins
Bleeding Disorders	Eye Problems	Kidney Problems	Rheumatic Fever	Venereal Disease
Blood Clots	Fainting	Leg Cramps	Seizure Disorders	Weight Loss, unexplained

Family History

List Relationship to you of family members who have had: Foot Problems: __________Arthritis: __________ Cancer: _________

Diabetes: _____________ Heart Problems: _____________ High Blood Pressure: _____________ Other: ___________________

Past Surgical Procedures/other Hospitalization:

Surgical History & Date | Hospitalization History & Date

____] [_______________________
____] [_______________________
____] [_______________________
____] [_______________________
____] [_______________________
____] [_______________________

Have you previously had a **Blood Transfusions**: Yes/ No   Have you previously been exposed to **Hepatitis:** Yes/ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: ________________________________

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Pharmacy Name: ______________________ Location: _____________________ Phone #:________________

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: __________ Anticoagulants: ____________Aspirin:___________ Codeine: _______________ Demerol: ___________

Iodine: _______Local Anesthetics: ________ Novocain: __________ Penicillin: ____________Seafood: ________ Sulfa: __________

Other: ____

Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No

Emergency Contact Name: ________________________ Relationship: _____________ Phone: ___________________________________

Names of family/friends who can pick up your records and/ medical supplies: ____

Names of family/friends that have parents' authorization to bring in the Minor child when guardian is absent:

____

Privacy Authorization for Use or Disclosure of Protected Health Information (PHI)
Required by the Health Insurance Portability and Accountability Act, (HIPAA) 45 C.F.R.Parts 160 and 164

I authorize Michael A, Garvin, DPM, PA to use and disclose my protected health information including my complete health record (which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). This authorization shall be in force and effect until I revoke this authorization, in writing. This medical information may be used by Michael A, Garvin, DPM, PA for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

NOTICE OF PRIVACY ACT
I have read a copy of Michael A, Garvin, DPM, PA. Notice of Patient Privacy Practices. ___________________________________ (Signature)

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Michael A, Garvin, DPM, PA. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions.____ (Signature)

MEDICARE AND INSURANCE AUTHORIZATON
I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Michael A, Garvin, DPM, PA. for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent's; the information needed to determine these benefits or the benefits payable for any 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 physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.____ (Signature)

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment from Michael A, Garvin, DPM, PA.

Print Patient's Name: ____

Representative's Signature: ____ Date: ____________________