Patient Chart Number
_____

Community Foot Specialists
DaytonFeet.com 937-426-9500

Patient Registration Form

Demographics

Patient Name: (Last, First, Middle initial) Gender at Birth ☐ Male ☐ Female	**Primary Physician**: _____ Last Day Seen: _____ Phone: _____
Patient's Full Address:	**Emergency Contact** _____ Relationship: _____ Phone Number: _____
Telephone ( ) Cell Phone ( ) Date of Birth ____/____/_____	Social Security Number: _____ Email: _____
Race: Ethnicity:	Primary Language:
Employer / Occupation:	Employer Phone:

Insurance Information

Primary Insurance Company Name:	Secondary Insurance Company Name:
Identification Number: Group Plan Number:	Identification Number: Group Plan Number:
Card Holder Name: Date of Birth:	Card Holder Name: Date of Birth:
Card Holder SSN Relationship with Patient Self / Spouse / Parent	Card Holder SSN Relationship Self / Spouse / Parent
**** If the patient is under the age of 18, please complete the section to the right by a parent/ guardian.**	Name: _____ Date of Birth: _____ SSN: _____ Relationship: _____ Address if Different: _____

Pharmacy Information

Name: _____	Location: _____ Phone Number ( )

_____ _____

Signature of Patient ***OR*** Parent/Guardian of minor under 18 Date

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Medical History

Height _____ Weight _____ Shoe Size_____ Pregnant/nursing_____ Last A1C_____%

Please indicate if you have any of the following conditions.

❑Arthritis ❑Asthma ❑Alcoholism ❑Back Problems ❑Cancer ❑Circulatory Problems ❑Depression ❑Diabetes ❑Fibromyalgia ❑Neuropathy ❑Heart Disease/CHF ❑COPD ❑Hemophilia ❑Hepatitis ❑HIV/AIDS ❑Kidney Disease ❑Osteoporosis ❑Stroke/TIA ❑Ulcers of feet/stomach ❑Other_____

Explain any of the above: _____

_____

_____

Current Smoker? Yes // NO **Former Smoker:** Yes // NO: quit date _____

Do you consume: Alcohol//Caffeine //Illegal Drugs//Marijuana (Please Circle those that apply)

Please circle if you have any of the following: Metal or Artificial Joint//Pacemaker//Defibrillator//Stents//Heart Surgery

Where and when: _____

Any foot or ankle surgeries? YES // NO Approximate date preformed_____

Any Surgeries? _____

Last date of foot exam if applicable_____provided by_____

Explain your foot/ankle issue for today's visit.

_____

_____

Allergies: Please list all allergies that you have. Check none if you have no known allergies:

❑None ❑Adhesive/Tape ❑Codeine ❑Lidocaine/Marcaine/Novocain ❑Shellfish ❑Sulfa

❑Ibuprofen/Advil/NSAIDS ❑Iodine/contrast dye ❑Penicillin ❑Bee or Insects Stings

❑Other _____

Please indicate the severity and type of reaction for any of the above:

_____

Medications: Please list all current medications. Include over the counter medications and vitamins.

_____

_____

_____

_____

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Privacy Practices, Protected Health Information and HIPPA

Community Foot Specialists understands that medical information about you and your health is personal. We are committed to protecting that information and will disclose your health information expressly for the following purposes: to treat you, assist other healthcare providers in treating you, allow insurance companies to process claims for rendered services, obtain payment for services rendered to you, and for certain limited operational activities such as quality assessment, licensing, accreditation and training.

Except for the aforementioned reasons, we will not use or disclose your health information without written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notice in effect within our facility.

In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) indicated below. **This can include: any/all members of immediate family, spouse, employer, school, or any other person. Additional members may be added in-person at any visit.**

_____ _____

Name & Relationship to Patient **Name & Relationship to Patient**

Patient Rights:

To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
To receive an accounting of certain health information disclosures we have made. To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
To request that we communicate with you in confidence, in a certain way or at a certain location. For example, you can ask if we only contact you by mail or at work.
To request that we amend your health information if you feel the medical information we have about you is incorrect or incomplete. To receive notice of our privacy practices by requesting a paper copy at any time.

Payment Policy

Acknowledgement of Payment Policy/Notice of Privacy Practices

Payment Policy: I have read and fully understand the payment policy of Community Foot Specialists. I acknowledge my rights and responsibilities and agree to act in accordance with the policy set forth. I understand that if I fail to comply with the policy, Community Foot Specialists reserves the right to dismiss me from the practice. NO SHOW Policy: we reserve the right to charge a fee in the amount of $60 for any appointment that is missed and a fee in the amount of $100 for any Surgical Procedure or surgery consultation that is missed.
Privacy Practices: I acknowledge that I was provided with a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.
Consent - I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

_____ _____

Signature of patient or legal representative **Date**

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HIPAA RELEASE AND AUTHORIZATION OF MEDICAL RECORDS

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **SSN:** _____

Medical Records. I hereby authorize _____("releasor") to use or disclose the following:

- **ALL MEDICAL RECORDS.** I request the release of all my complete health record, which may or may not include protected health information and electronic protected health information, protected under **HIPAA**.

  Restrictions – medical information related to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall:
  - – Be Included
  - – Not be Included

- **Specific Medical Records:** _____

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: _____ Phone: _____ Fax: _____

Address: _____

Purpose of Release: _____

I understand that signing this authorization is voluntary and that my treatment, payment enrollment in a heal plan, or eligibility form benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA

A copy of this authorization is as valid as the original.

Patient or Representative Signature: _____
Printed Name: _____ Date: _____
Representative Relationship to Patient: _____