Foot&Ankle OF THE CAROLINAS

# PATIENT REGISTRATION SHEET

*A division of the NC Podiatric Physicians and Surgeons Group, PLLC*

**PATIENT INFORMATION** **Today's Date** _____

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: M / F

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-Mail: _____

Social Security Number: _____ Date of Birth: _____ Marital Status: S / M / D / W

Guardian: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Group: _____ Date of last visit: _____

Employer: _____ Phone: _____ Occupation: _____

***Please tell us how you heard about our office***: _____ ***Referred by***: _____

**INSURANCE INFORMATION**: (Please allow receptionist to photocopy your insurance cards and a drivers license with photo ID)

Primary Insurance Plan: _____ Policyholder Name: _____

Policyholder DOB: _____

Relationship to Policyholder: _____

Secondary Insurance Plan: _____ Policyholder Name: _____

Policyholder DOB: _____

**Receipt of Notice of Privacy Practices**

I attest that I have been provided or have received a copy of the Foot & Ankle of the Carolinas Notice of Privacy Practices. _____SIGN____DATE

**Insurance Assignment and Release**:

I certify that I have insurance coverage with the above listed company and authorize Foot & Ankle of the Carolinas to submit claims to my insurance company for any services rendered to me. I assign all insurance benefits to be paid directly to Foot & Ankle of the Carolinas. I understand that I am financially responsible for all charges whether or not paid by my insurance. Foot & Ankle of the Carolinas may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits of related services.

_____SIGN_____DATE

**Consent for Healthcare and Release of Medical Information**:

I voluntarily consent to healthcare treatment from the physicians and staff at Foot & Ankle of the Carolinas. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of treatment or the examinations by my caregivers. I consent to the use of health information about me for treatment and communication of healthcare operations. I have read this form and have had the opportunity to ask questions regarding my healthcare and treatment.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____ Date: _____

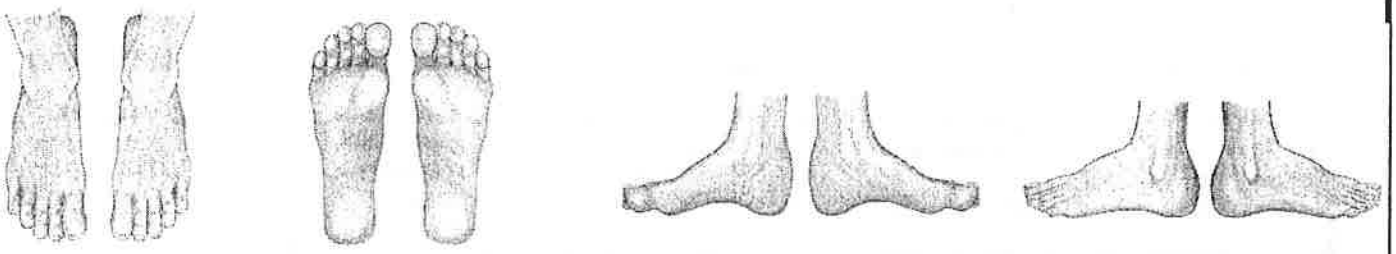
Age: _____ Height: _____ Weight: _____ Shoe Size: _____ Race: _____ Ethnicity: _____ Language: _____

**CHIEF COMPLAINT:** ( nature of your problem or pain): _____

_____

If injury/Date of injury: _____ Work Related: Yes _____ No _____ Contact Administrator: _____

Location of Pain: ( *please mark the area of your problem's on the below diagram with an "X")* ☐ Right ☐ Left



How long has this bothered you? _____ How did it start? _____

Can you describe the pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Numbness ☐ Tingling ☐ Localized ☐ Radiating ☐ Swollen ☐ Hot

What aggravates it? _____ What relieves the condition? _____

Have you been treated for this condition by another Physician? yes____ no____ Physician/Date_____

**Previous Medical History:** (Please check if **You** or your *Family* are currently or have been treated for any of these in the past)

| YOU *Family* | YOU *Family* | YOU *Family* | YOU *Family* | YOU *Family* |
|---|---|---|---|---|
| ☐☐ Diabetes | ☐☐ Heart Disease | ☐☐ Arthritis | ☐☐ Liver Disease | ☐☐ Anemia |
| ☐☐ Neuropathy | ☐☐ Heart Attack | ☐☐ Rheumatoid | ☐☐ Hepatitis | ☐☐ Anxiety/Depression |
| ☐☐ Kidney Disease | ☐☐ Pacemaker | ☐☐ Lupus | ☐☐ HIV | ☐☐ Thyroid |
| ☐☐ Dialysis | ☐☐ Stroke | ☐☐ Psoriasis | ☐☐ Lung Disease | ☐☐ Muscle Disease |
| ☐☐ Cholesterol | ☐☐ Blood Clot | ☐☐ Gout | ☐☐ COPD | ☐☐ Bone Disease |
| ☐☐ Hypertension | ☐☐ Cancer | ☐☐ Fibromyalgia | ☐☐ Sleep Apnea | ☐☐ Osteoporosis |

**Past Surgical History/Hospitalizations**: (List surgery and date) Any Complications with anesthesia? ☐ yes ☐ no

_____

_____

**Social History:** Do you smoke Tobacco? ☐ No ☐ Yes Packs per day: _____ Years: _____ ☐ Former Smoker

Do you drink Alcohol? ☐ No ☐ Yes How often? _____

Women: Are you Pregnant/Breast feeding ? ☐ No ☐ Yes Are you claustrophobic ☐ No ☐ Yes

**Medications**: (Please include dosages if possible) ☐ Medication list provided

_____

**Allergies**: (Are you allergic or sensitive to any of the following) ☐ No Known Drug/Medication Allergies

☐ Penicillin ☐ Morphine ☐ Novocaine ☐ Latex ☐ OTHER: _____

☐ Sulfa ☐ Codeine ☐ Iodine ☐ Neosporin **REACTION** to allergen: _____

# Welcome to our New Patients

Welcome to our practice! We appreciate the opportunity to be of service to you and hope that you will be pleased with our services. We strive to not only meet, but exceed your expectations on every level.

Our practice is a division of the NC Podiatric Physicians and Surgeons Group, PLLC. We have divisions across the state, and we operate under one tax id number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at the NCPPSG as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2013 do not need to be disclosed.**

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a ✓ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

| | Division | Podiatrist |
|---|---|---|
| ___ | Alta Ridge Foot Specialists | Robert van Brederode, William Broyles |
| ___ | Ankle & Foot Center of Charlotte | Scott Basinger |
| ___ | Brunswick Foot & Ankle Surgery, PA | Joseph Kibler |
| ___ | Carmel Foot Specialists | Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan |
| ___ | Carolina Foot Care Associates, PLLC | Ashma Davidson, Terry Donovan, William O'Neill |
| ___ | Central Carolina Foot & Ankle Associates | Melissa Hill, John Iredale, Gary Liao, Phill Ward |
| ___ | Chapel Hill Foot & Ankle Associates, P.A. | Nicholas Adams, Jane Andersen, Alan Bocko |
| ___ | Charlotte Foot & Ankle Specialists, PLLC | Kristine Strauss |
| ___ | Comprehensive Foot & Ankle Center, P.A. | Zack Nellas |
| ___ | Crystal Coast Podiatry | Thomas Bobrowski |
| ___ | Eastern Carolina Medical Center | Scott Matthews |
| ___ | Eastover Foot & Ankle, P.A. | Chris Fuesy, Ron Futerman, Kent Picklesimer |
| ___ | Edgewater Medical Center | Scott Matthews |
| ___ | Family Foot & Ankle Center, P.A. | Patrick Dougherty, Doug Smith |
| ___ | Family Foot Care | Kevin McDonald, Tori Simmons-Lewis |
| ___ | Foot & Ankle Ctr of Durham | Eric Simmons |
| ___ | Foot & Ankle of the Carolinas, PLLC | Eric Ward, Blaise Woeste |
| | Gaston Foot & Ankle Associates, P.A. | David Kirlin, Ryan Meredith, Wagner Santiago |
| ___ | Greensboro Podiatry Associates, P.A. | Martha Ajlouny, N'Tuma Jah |
| ___ | Hendersonville Podiatry | Russ Barone, Pam Stover |
| ___ | James Mazur, D.P.M., P.A. | James Mazur |
| ___ | Matthews Foot Care | Brian Killian, Kevin Killian |
| ___ | Mt. Airy Foot & Ankle Center, PLLC | Jim Shipley |
| ___ | Piedmont Foot & Ankle Clinic | Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Scott Matthews |
| ___ | Queen City Foot & Ankle Specialists, P.C. | Roxanne Burgess |
| ___ | Raleigh Foot & Ankle | Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer |
| ___ | Ryan Foot & Ankle Clinic | David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman |
| ___ | Salem Foot Care | Walter Falardeau |
| | Wake Foot & Ankle Center | Mike Hodos, Jim Judge |
| ___ | Wilson Podiatry Associates, PA | Kendall Blackwell |

___ I attest that I have been seen in the above indicated division of the NCPPSG since 01/01/2013.

___ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2013.

Signature of patient: _____ Date: _____

Printed Name: _____ DOB: _____

# Authorization for Release of Information
# Foot & Ankle of The Carolinas

Name of Patient _____ Date of Birth _____

_____ **is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.**

| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ❑ Voice Mail | ❑ Results of lab tests/x-rays<br>❑ Financial |
| ❑ Spouse (provide name & phone number)<br>_____ | ❑ Financial<br>❑ Treatment |
| ❑ Parent (provide name & phone number)<br>_____ | ❑ Financial<br>❑ Treatment |
| ❑ Other (i.e. Stepparent, Grandparent, Nanny)<br>_____ | ❑ Financial<br>❑ Treatment |

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Revised January 2010