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PATIENT REGISTRATION FORM

Patient Name: ____ DOB____/____/_____ Age: _____

Street Address: ____

City: ______________________________ State: ________ Zip: __________

Home Phone #: (_______) _______-_______ Cell #: (______) _______-_______ TEXT: YES OR NO

Social Security #: ______-_____-______ Sex: M / F Patient Status (Circle one): M / S / D / W

Race:__________________ Ethnicity:______________ Preferred Language:_____________________

E-Mail Address: ____

Providing your email address gives you the ability make and change appointments in real time as well as allowing AAL Podiatry Associates the ability to communicate with you through our "Patient Portal".

Are you employed Yes or No? *Employer's Name*: ____

Job title or Dept.: ____________________________ Phone #: (_____) ______-_____ext.:____________

Responsible Party: _____________________________Cell Phone#: (___) ____-______ Relation:__________

Emergency Contact: ______________________________Relationship to Patient: _______________________

Emergency Contact Circle One Home or Cell #: (_____) _______-_______

Preferred Pharmacy: ____ Phone#:(____)_______-________

Please add city and/or store #

How did you learn about us: ( ) PCP, ( ) Friend, ( ) Internet, ( ) Hospital, ( ) Yellow Pages, ( ) Insurance Plan, ( ) Other_____________________

	Your Doctor(s) Name	Last Date Seen	Referred (Circle one)
Primary Physician			**Yes or No**
Specialist			**Yes or No**
Other Podiatrist			**Yes or No**

When you have been scheduled for an appointment, we ask that you please contact our office 24 hours in advance, if for any reason you cannot make your appointment.

I understand and agree that (regardless of my insurance) I am responsible for any professional services rendered because my insurance may not cover certain procedures

Signature____ Date________________

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FINANCIAL AGREEMENT and INSURANCE ASSIGNMENT

Policy Holders Name: _______________________________

Address (if different than patient):____

DOB____/____/_____ Social Security # _______-_____-_______ Employer: _________________________

<u>Primary Insurance Name:</u> ____

Relationship to Insured (Circle one): self, spouse, child, guardian

Policy Number: ______________________________________ Group# _________________________

Are you covered by a secondary insurance (Circle one)? (YES/NO) If yes please fill out following:

Policy Holders Name: _______________________________

Address (if different than patient):____

DOB____/____/_____ Social Security # _______-_____-_______ Employer: _________________________

<u>Secondary Insurance Name:</u> ____

Relationship to Insured (Circle one): self, spouse, child, guardian

Policy Number: ______________________________________Group#__________________________

Official Use:

I certify that patient has active Insurance coverage with the following insurance company(s):

____

(LIST ALL)

<u>INSURANCE ASSIGNMENT AND RELEASE</u>

I assign directly to AAL PODIATRY ASSOCIATES all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges when they are not covered by insurance and for all co-pays, deductibles and coinsurance. I authorize the use of my signature on all insurance submissions whether electronic or manual method. AAL PODIATRY ASSOCIATES may use my health care information and disclose such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. I request that payments of authorized Medicare benefits and/or Madigan benefits be made on my behalf to AAL PODIATRY ASSOCIATES for any services furnished to me. To the extent by law, I authorize AAL PODIATRY ASSOCIATES, holder of medical or other information about me to release it to the Centers for Medicare and/or Medicaid Services, Madigan, my Primary Commercial or Secondary insurer, or their agents any information needed to determine my benefits for related services. <u>I agree that should my account become delinquent and is referred to a collection attorney I will be responsible for all cost of collection and attorney fees of 33.33% on unpaid balances at the time of referral</u>

Responsible for the Account:

____ ______________________________

(Patient/Guardian/Personal Representative) Printed Name **Relationship to Patient**

____ ___________________

(Patient/Guardian/Personal Representative) Signature **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

NAME____ **DOB**_____/_____/______

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have the right to request a restriction on uses and disclosures of my protected health information (PHI). I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
*Receiving medical information through our Patient Portal
* Obtain payment from third-party payers
* Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients* 18 *and over must complete the following:

I hereby authorize AAL PODIATRY ASSOCIATES to use or disclose the following:

( ) All Protected Health Information **( ) Other** _______________________

____

My PHI may be disclosed to: (name of any family or friend we may disclose your information to)

Name of Person(s), relationship to Patient, and phone number:

____

____

This authorization shall be in force and effective until: (check one of the following)

( ) No expiration **( ) other** ____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: *Dr. Jesse Anderson III, AAL PODIATRY ASSSOCIATES, 301 Riverview Ave, Suite 510, Norfolk, Va. 23510.*

I understand that I have the right to:

- Inspect or copy my PHI to be used or disclosed as permitted under federal law (or Virginia Law)
- Refuse to sign this authorization
- Also to provide any documentation proving guardian ship or power of attorney

I HAVE READ THE ABOVE NOTICE OF PRIVACY PRACTICES & AGREE TO ABIDE BY IT.

Signature of Patient or Personal Representative: ____

Relationship to Patient ___________ **Date** ______________

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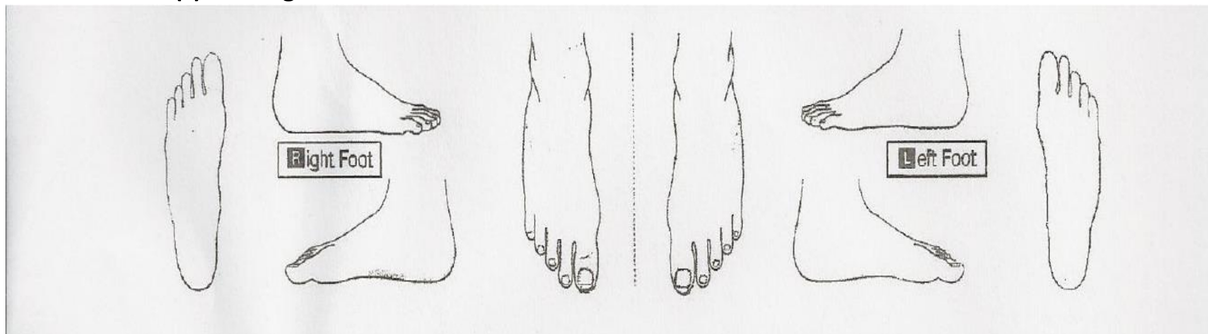
CHIEF COMPLAINTS

Mark the Area(s) causing the discomfort



Describe the Problem: ____

When did it start or how long have you had the discomfort? ______(circle one) days/months/years ago

Was it caused by an injury? Yes or No Was the injury work related? Yes or No Date:_____/_____/_______

(circle all that applies)Pain occurs when: Walking or Not walking or All the time At night?

Pain appears to be worse during first steps after sitting or getting out of bed? Yes or No

Does the pain subside or worsen with each step? Yes or No

Describe the Pain (circle all that apply) Dull, Ache, Burning, Throbbing, Itch, Tender, Tingle, Numb?

Level of Pain from 1 to 10?_____________

What aggravates the problem? ____

What relieves the problem? ____

Does the pain travel Yes or NO? Where? ____

Is there anything else you wish to discuss about your foot/ankle problem(s)?

____

____

Signature: ____**Date** ________________________

For Doctor's use only

****

Patient was aided in completion of the records by _____________________________________
Additional information was obtained by ____
Guardian(s) present with patient____
The following where reviewed:
Lab reports ____
Previous Medical Records____
Radiological findings____

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MEDICATIONS

Drug Name Dose Frequency

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

Medical History

(Please check any of the following medical conditions that you are presently being treated for or have been treated for in the past).

☐ Anemia	☐ Diabetes	☐ Hyperthyroidism	☐ Rheumatoid Arthritis
☐ Anesthesia Reaction	☐ DVT	☐ Hypothyroidism	☐ Schizophrenia
☐ Angina Pectoris	☐ Emphysema	☐ Irregular Heartbeat	☐ Scleroderma
☐ Anxiety	☐ Fibromyalgia	☐ Kidney Failure	☐ Seizures
☐ Arthritis	☐ GI Ulcers	☐ Kidney Stones	☐ Sickle Cell
☐ Asthma	☐ Gout	☐ MI (Heart Attack)	☐ Sinusitis
☐ Bleeding Problems	☐ Heartburn	☐ Osteoarthritis	☐ Sleep Apnea
☐ Cancer (specify type: _______________)	☐ Heart Disease	☐ Paralysis	☐ Stroke
☐ Cirrhosis	☐ Heart Murmur	☐ Peripheral Vascular Disease	☐ Systemic Lupus Erythematosus
☐ Colitis	☐ Hemorrhoids	☐ Prostate Disease	☐ TB
☐ Colorectal Polyps	☐ Hepatitis	☐ Psoriasis	☐ Ulcers
☐ COPD	☐ Hypertension	☐ Pulmonary Embolus	☐ Urinary Tract Infections
☐ Crohn's Disease	☐ High Cholesterol	☐ Reflux/Heartburn	☐ Other
☐ Depression	☐ HIV/AIDS	☐ Rheumatic Fever	

Please check any foot conditions treated:

☐ Corns/Callus	☐ Fungal Nails	☐ Warts	☐ Athletes' Foot
☐ Leg/Foot Ulcers	☐ Neuroma	☐ Ingrown Nail(s)	☐ None of these
☐ Broken Foot Bones	☐ Broken Ankle	☐ Foot Numbness	
☐ Hammertoe(s)	☐ Bunion(s)	☐ Ankle Sprain(s)	
☐ Cramps in legs and feet	☐ Arch Pain	☐ Flat Feet	
☐ Lower back pain	☐ Knee Pain	☐ High arch feet	
☐ Gait (walking problems)	☐ In-toeing	☐ Heel Pain	
☐ Childhood foot problems	☐ Rash	☐ Toe walking	

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ALLERGIES

1.____________________________________ Reaction: ____________________________________
2.____________________________________ Reaction: ____________________________________
3.____________________________________ Reaction: ____________________________________
4.____________________________________ Reaction: ____________________________________
5.____________________________________ Reaction: ____________________________________

Have you had any adverse reaction to anesthesia? If so, please describe:
____

Are you in Pain Management? Yes Or NO Providers Name:________________________

SURGICAL HISTORY (Please check all that apply):

☐ Appendectomy	☐ Leg Artery Bypass	☐ Hip Fracture	☐ Shoulder Replacement
☐ Arthroscopy	☐ Tarsal Tunnel	☐ Hip Replacement	☐ Tennis Elbow
☐ Coronary Artery Bypass Graft/Stent	☐ Fracture	☐ Knee Replacement	☐ Tonsillectomy
☐ Carpal Tunnel	☐ Hemorrhoidectomy	☐ Mastectomy	☐ Trigger Finger Release
☐ Cervical Surgery	☐ Hernia Repair	☐ Prostatectomy	☐ Ankle Surgery
☐ Bunion Surgery	☐ Toe Surgery	☐ Other	

FAMILY HISTORY: (Please check the appropriate family member)

Arthritis - Rheumatoid	☐ Mother	☐ Father	☐ Sister	☐ Brother
Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother
Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother
Kidney Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother

SOCIAL HISTORY

Do you smoke: Yes No
How many packs per day? __________
How many years? _________________
If quit, when? _____________________

Do you drink alcohol: Yes No
What type? _______________________
How much per week? ______________

Recreational Drug Use: Yes No
If yes, What type? __________________

Females:

Are you pregnant/nursing? Yes No
Could you be pregnant? Yes No
Are you post-menopausal? Yes No
Date of last menstrual period: ________________________

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REVIEW OF SYSTEMS: (Please check all that apply):

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Malaise/Fatigue
- ☐ Weakness

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Redness

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Blood in stool
- ☐ Diarrhea

Skin
- ☐ Rash
- ☐ Itching

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Orthopnea
- ☐ Claudication
- ☐ Leg swelling
- ☐ Peripheral Neuro deficit

Genitourinary
- ☐ Dysuria
- ☐ Hematuria
- ☐ Flank Pain

Neurological
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Loss of consciousness

HENT
- ☐ Headache
- ☐ Congestion
- ☐ Sore throat

Respiratory
- ☐ Cough
- ☐ Hemoptysis
- ☐ Sputum production
- ☐ Shortness of breath

Musculoskeletal
- ☐ Myalgia's
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain

Psychiatric
- ☐ Depression
- ☐ Insomnia
- ☐ Memory loss
- ☐ Wheezing

Patient:
HT: __________ WT: ________ Shoe Size:_________

Date: __________ Initials: __________