Advanced FOOTCARE
CARING FOR YOUR FAMILY'S FEET

Patient Registration Form

Personal Information

Today's Date: ________________

First Name: ______________ MI: ______ Last Name: ______________

DOB: _____/_______/_______ Social Security #: _____-_________-_______ Gender: Male / Female / Other

Race: White / Asian / African American / Hispanic / Latino / Pacific Islander / Native American

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

What is your preferred language? English / Spanish / Mandarin / Italian / Other: ____________

Home Address: _____________________ City: ______________ State: ____________ Zip Code:

Employment Information

Are you: Employed / Unemployed / Student / Child / Retired

If employed, please provide the name of your employer: ____

Are you a member of a Union? Yes / No. If yes, Local# _______________

Who may we thank for Referring you?

ZocDoc / Webiste / Insurance / Google / Friend / Physician Referral Other: ________________________

Communications & Emergency Contact Information

Cell Phone # (_________)-___________-___________ May we leave a voicemail? Yes / No

Home Phone #(_______)-___________-____________ Email address: __________________@____________

May we send you an email or text messages? Yes / No. Emergency contact name: _______________________

Emergency Contact Phone # (_____) -___________-___________ Emergency contact relation: _______________

Insurance and Guarantor Information

Do you have health insurance: Yes / No Name of insurance company: ___________________________

Insurance ID#: ___________________ Are you the primary policy holder? Yes / No, If no please complete below

Relationship to policy holder: Spouse / Parent / Domestic Partner. Policy holder's full name: __________________

Policy holder's date of birth: ___/____/_____ Is the policy holder's address same as yours? Y / N

If no, please provide the policy holder's address: _______________________________________

Do you have a secondary insurance? Y / N Name of insurance company: __________________________

Are you the secondary policy holder? Y / N. If no, please provide policy holder's full name: __________________

Policy holder's date of birth:___/___/___ Is the policy holder's home address same as yours? Y / N

If no, please provide the policy holder's home address: ____________________________________

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Primary Medical Doctor

Who is your Primary Medical Doctor? ____

What is the address of you Primary Medical Doctor? ______________________________

What is their office phone number? (_____) - ______ - _________

Do you see a specialist (Endocrinology, Cardiologist, Vascular Surgeon) ? ________________________

Doctors Name: ________________ Date of last medical visit: ____/______/_____

Pharmacy Information

What local pharmacy do you use? ____________________

What is the address where your pharmacy is located? ____

May we electronically request your RX history from your pharmacy? Yes / No

By signing below, I authorize Advanced Foot Care to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Advanced Foot Care, and it may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my Advanced Foot Care medical record. I also give permission for Advanced Foot Care to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____

Patient Signature

Allergy Questions

Do you have any material, medication or food allergies? Yes / No

If Yes, what is your allergy? (Circle all that apply)

epinephrine / aspirin / codeine / penicillin / cortisone / iodine / sulfa / tetracycline

erythromycin / Demerol / morphine/ latex / Levaquin / Cipro/ seafood/ adhesive

Other:__________________ Other:__________________ Other:__________________

Are you currently taking any prescription or over-the-counter medications? Yes / No
If Yes, Please complete below;

Name of Medication	Name of Medication
_______________________________	_______________________________
_______________________________	_______________________________
_______________________________	_______________________________
_______________________________	_______________________________

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Medical Conditions

Do you have any medical conditions? Yes / No

If Yes, please circle all that apply, even if you are taking medication for the condition.

Alzheimer's or memory loss / anemia / anxiety / atrial fibrillation / back problems / bleeding disorder/

cancer, type________________________ / COPD / congestive heart failure / coronary artery disease / diabetes /

GERD / glaucoma / hearing loss / heart valve problem / heart attack or MI / heart problem / hepatitis /

high cholesterol / HIV or AIDS / hypertension / kidney disease / liver disease / migraines / Parkinson's /

peripheral arterial disease / peripheral neuropathy / prostate problem / psoriasis / Raynaud's / rheumatoid arthritis

seizure disorder / skin cancer / stroke or TIA / thyroid problem / vision problems /

other________________________ other_____________________ other_______________________

Surgeries

Have you had any surgeries? Yes / No (If Yes, please circle all that apply)

appendix / back / bariatric / bladder / bypass legs / bypass heart / cataract / colon / gallbladder / heart valve / kidney

liver / Organ transplant, organ_________________ / prostate / replacement hip / replacement knee / thyroid /

vein stripping /

other________________________ other_____________________ other_______________________

Smoking and Immunizations

Do you currently smoke cigarettes? Yes / No If yes, how many packs per day do you smoke? ____________

Have you smoked in the past? Yes / No If yes, when did you quit? This year / 1-5 years ago / +5 years ago

Do you drink alcohol regularly? Yes / No If yes, how much? 1 drink per week / 1 drink per day / +1 daily

Have you had a flu shot this year? Yes / No If yes, when,____________________

Have you had a pneumonia (pneumococcal pneumonia) vaccine? Yes / No. If yes, when,____________________

Have you had a COVID vaccine this year? Yes / No If yes, when,____________________

Height: _______________ **Weight:**________________ **BP:**__________________**Shoe Size:** ________________

Patient Registration Form

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, ____________________________ hereby authorize Advanced Foot Care (the practice) to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize the practice to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I request payment from my insurance company or Medicare to be made directly to the practice. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. This authorization may be revoked at any time by me with written notice to the practice. Most insurance plans require that patient authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient cannot sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We cannot call your doctor to request a referral on your behalf. If you have a co-pay, it is due at the time of the visit.

Regardless of your insurance plan, you are financially responsible for payment. If the claim we submit is not paid by your insurance plan within 90 days, we consider the claim as “not covered” by your plan, and you will become financially responsible. Should your account go to collection, you agree to pay any and all expenses, including collection fees or percentages.

Acknowledgement of Practices Notice of Privacy Practices

By signing my name below, I acknowledge that I am aware that a copy of the Notice of Privacy Practices (NPP) is available to me (copy located in waiting room) and I have had the opportunity to read, if I so chose, and understand the Notice of Privacy Practices (NPP) and agree to its terms. I may request and receive a printed copy of the NPP upon request.

MEDICARE PATIENTS ONLY:

I request that payment of authorized medical and surgical benefits and supplies be made to Advanced Foot Care on my behalf or any covered dependents. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS:

As a self-paying patient I understand that I am responsible for and will pay for all medical/podiatric services at the time of the visit.

I have read, understand and agree to the above.

________/___________/____________
Today’s Date

____
Patient’s Name (Please Print)

____
Patient's Signature

____
If under 18 years old, Patient’s Guardians Name (Please Print)

____
If under 18 years old, Patient’s Guardians Signature

Designation Of Patient Spokesperson

(PHI)

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information: Please Print

Patient Name:____ Date Of Birth:____________________

Address:____ Phone #:_________________________

Authorized Individual: Please Print

Name:____ Relation To Patient:______________

Address:____ Phone #:_________________________

I grant to the individual named above to have access to:
_______ All of my PHI
_______ Other- Specify limits or specific health care incident

1. I understand that I may revoke these designations at any time by notifying the appropriate Advanced Foot Care in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Advance Foot Care prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPPA

4. I understand that this authorization will: (Must check one)
( ) expire 1 year from the date executed OR ( ) be effective for the lifetime of the patient unless revoked

Signature of Patient/Personal Representative:____

Name Of Personal Representative:___________________________________ Date:____________________

Relationship to patient:____

YOU MAY REFUSE TO SIGN THIS FORM

Consent to Receive Text Messages

Our office offers the convenience of communicating with you via text message for appointment reminders, notifications, and other relevant information regarding your care. By signing this consent form, you agree to receive text messages from our office.

Text messages may include, but are not limited to:
Appointment reminders
Scheduling changes
Health care instructions
Information on services and office updates

Standard text messaging rates may apply, based on your cellular service plan. While we strive to ensure the confidentiality of your information, text messaging may not be a secure method of communication. By consenting, you acknowledge and accept this risk. You have the right to opt out of receiving text messages at any time. To opt out, please notify our office in writing or respond to any received text message with the word "STOP." It is your responsibility to inform us of any changes to your mobile number. Our office is not responsible for messages that are not received due to incorrect or outdated contact information.
By signing below, you acknowledge that you have read, understand, and agree to the terms outlined above. You consent to receive text messages from our office at the provided phone number.

Signature of Patient/Personal Representative:____

Name Of Personal Representative:____________________________________ Date:___________________

Relationship to patient:____

YOU MAY REFUSE TO SIGN THIS FORM