Foot and Ankle Center of Chester County

REGISTRATION (Please Print)

PATIENT INFORMATION

Name_____/_____/_____ Soc. Sec#_____-_____-_____ Gender: Male Female
(Last) (First) (Initial)

Address_____City, State,Zip_____Birth date ____/_____/_____

Patient Employed by_____ Marital Status: S M D W

Home Phone: (_____) _____-_____ Mobile Phone (_____) _____-_____ Work Phone (_____) _____-_____

I authorize the office to leave a message for me: ☐ At home ☐ At work ☐ Mobile Phone ☐ E-Mail:_____

In case of emergency who should be notified? _____ Phone (_____) _____-_____

Primary Care Physician or Referring Physician

Referring Physician: _____ Phone (_____) _____-_____ Last seen: _____

Primary Physician: _____ Phone (_____) _____-_____ Last seen: _____

Address: _____ City, State, And Zip: _____

Primary Insurance

Subscriber: _____/_____/_____ Soc.Sec #:_____-_____-_____ Birth date: _____/_____/_____
(Last) (First) (Initial)

Relation to Patient: _____ Phone: (_____) _____-_____

Address (if different from patients):_____City, State, Zip: _____

Insurance Name: _____ Effective Date: ____/____/_____ Policy #:_____ Group #:_____

Secondary Insurance

Subscriber: _____/_____/_____ Soc.Sec #:_____-_____-_____ Birth date: _____/_____/_____
(Last) (First) (Initial)

Relation to Patient: _____ Phone: (_____) _____-_____

Insurance Name: _____ Effective Date: ____/____/_____ Policy #:_____ Group #:_____

How Did You Hear About Us?

Yellow Pages Newspaper Insurance plan Primary Care Provider ER Friends/Family Internet Other: _____

Authorization and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named Insurance Company and assign directly to Foot and Ankle Center of Chester County 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____ Relationship_____ Date ____/____/_____

Foot and Ankle Center of Chester County

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the privacy notice.

Patient Name (please print): _____
Signature: _____ Date____/____/_____

Acknowledgment could not be obtained because:

- O Individual refused to sign.
- O Communication barriers prohibited the acknowledgement
- O An emergency situation prevents us from obtaining acknowledgement
- O Other:_____

General Office Policy

- Copay is due at the time of service. A $25 processing fee will be charged if your copay is not paid at the time of service.
- The patient is to understand his/her insurance coverage and responsible for any deductibles and obtaining referrals if required.
- Medicare patient: Medicare and secondary insurance does not always cover 100% of the medical service. We are required by law to collect the balance.
- Medical forms (i.e. disability, insurance, parking forms, chart copy's, workman's compensation,) incur $35 office charge. Summary of chart and detail report will be billed per doctor's hourly rate.
- Please kindly give 24 hours notice for appointment cancellation. A fee of $35 will be charged for missed appointments without 24 hour notice.
- For telephone prescription refill, the patient needs to be examined within 3 month time frame. Please kindly give 48 hours for prescription refill.
- Any outstanding balance over 90 days and/or three statements will be forwarded to collection agency.

Signature: _____ Date____/____/_____

Foot and Ankle Center of Chester County

NOTE: This is confidential record and will be kept at your doctor's office; Information contained here will not be released to anyone without your authorization to do so.

DATE: _____/_____/_____ RACE: American Indian, Asian, African American, Hispanic/Latino, White, Refuse to Report

LAST NAME: _____ FIRST NAME: _____ MIDDLE_____

HEIGHT: _____ WEIGHT: _____ MAIL ORDER PHARMACY:_____

Local Pharmacy: _____Address_____Telephone_____

CHIEF CONCERN:

What is the main reason for your visit today?				
Date of Injury:				
Location:	Left	Right	Both	Toe / Foot / Ankle
Nature:	Pain	Numbness	Burning	
Severity:	Mild	Moderate	Severe	
Duration:	Weeks	Days	Months	Years
Course:	Unchanged	Worsen	Improved	
Current Treatment:		Medication	X-Rays	MRI Other
Have you been treated by anyone else for this same problem?		No	Yes	

PAST MEDICAL HISTORY

☐ Diabetes Type I / Type II ☐ Poor Circulation ☐ Arthritis of Knee / Hip ☐ Wound Leg / Foot
☐ Congested Heart Failure ☐ Stroke ☐ Gout ☐ Liver Disease
☐ Foot / Ankle Fracture ☐ High Blood Pressure ☐ Heart Valve Disorder ☐ Kidney Disease
☐ Nail Fungus ☐ Bleeding Disorder ☐ Pacemaker ☐ Clots of lung or leg
☐ High Cholesterol ☐ Childhood foot disorder ☐ Neuroma of foot ☐ Ankle Sprain
☐ Athlete's foot ☐ Flat foot ☐ High Arch foot ☐ Painful Bunion / Toes
OTHER:

PAST SURGICAL HISTORY (List previous surgeries and when they occurred)

☐ Lower Extremity Bypass / Stent ☐ Replacement of Hip / Knee ☐ Heart Surgery
☐ Amputation of Foot / Toes / Leg ☐ Foot / Ankle Surgery ☐ Toe nail Surgery
OTHER:

MEDICATION (List all current drugs and dosage) ☐ None ☐ See list

SOCIAL HISTORY

Do you consume alcohol? Yes or No If yes how much? _____
Do you smoke? Yes or No If yes how many years? _____, and how many packs per day? _____
Do you use recreational drug? Yes or NO If yes please describe _____

ALLERGY (List all food or drug allergies) ☐ No Known Drug or Food Allergy

☐ PENICILLIN ☐ ASPIRIN ☐ TAPE/ADHESIVE ☐ IODINE/SEAFOOD
☐ SULFA ☐ NOVOCAINE ☐ CODEINE ☐ LATEX
OTHER:

Foot and Ankle Center of Chester County

REQUEST FOR RELEASE OF MEDICAL RECORDS

I _____hereby request, medical records to be released to:
(Name of Patient)

Foot and Ankle Center of Chester County
684 W. Lincoln Highway
Exton, Pa 19341
Tel (610) 269-0800
Fax (610) 269-0510

Medical Records information to be released:

___History: _____
___Diagnosis and treatment: _____
___Lab data: _____
___Imaging reports: _____
___Hospital records: _____
___Other: _____
___Any and all records, x-rays and any other medical information related to treatment.

However, I do not wish release of the following information that may be contained in my medical records to the above person or persons:

___Do not release the following: _____

___Do not release any records.

A photocopy of this Consent may be used instead of the original

_____
(Signature of patient, guardian, or authorized representative) Date

THE FOLLOWING NOTICE MUST ACCOMPANY DISCLOSURES:
If this consent pertains to drug or alcohol treatment, please note the following: This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.