***PINEHURST FOOT SPECIALIST, PA***

**PATIENT REGISTRATION** **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Social Security #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (FIRST) (M.I.) (LAST)

**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ **Age** \_\_\_\_\_ **Gender: Male or Female (circle one) Race\_\_\_\_\_\_\_ Language\_\_\_\_\_\_\_\_\_**

**Do You Live In A Nursing Home \_\_\_\_\_YES or \_\_\_\_\_NO Name Of Facility if YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (STREET OR PO BOX) (CITY) (STATE) (ZIP CODE)

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| **This is for person responsible for bill for someone under age 18 or someone with Power of Attorney that handles patient’s finances\_\_****Guarantor**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_

**Work Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children\_\_\_\_\_**

***Emergency contact*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Relationship to you*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone**#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**This is for person carrying insurance policy**

**Insurance Co \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Name of Policy Holder** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to you** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy **Holder SS#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policy Holder Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Doctor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Visit\_\_\_\_\_\_\_\_\_\_\_

**Have you ever seen a doctor for the same problems that you are seeing us for today**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last visit\_\_\_\_\_\_\_\_\_

**Specific reason for visit today**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List anything that you are *ALLERGIC* to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List *ALL* operations (on any part of body) you have had in the past** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List *ALL* medications (prescribed and over the counter)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHECK any of the following that you have been treated for in the past OR circle NONE now:**

\_\_\_\_\_AIDS \_\_\_\_\_Bleeding Disorder \_\_\_\_\_Heart Problems \_\_\_\_\_Liver Problems

\_\_\_\_\_Aneurysm \_\_\_\_\_Brain Tumor \_\_\_\_\_High Blood Pressure \_\_\_\_\_Thyroid Problems

\_\_\_\_\_Arthritis \_\_\_\_\_Cancer \_\_\_\_\_Joint Implants \_\_\_\_\_Tuberculosis(TB)

\_\_\_\_\_Asthma \_\_\_\_\_Epilepsy/Seizures \_\_\_\_\_Kidney Problems \_\_\_\_\_Diabetes\*\*If Diabetic, DO YOU USE \_\_\_\_\_Stroke \_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSULIN Yes or No (CIRCLE)

**HABITS:** \_\_\_\_Tobacco \_\_\_\_Alcohol \_\_\_\_Other

**FAMILY HISTORY(Circle M-Mother or F- Father if any of the following have occurred in your immediate family)**

M F AIDS M F Bleeding Disorder M F Epilepsy M F Kidney Problems

M F Aneurysm M F Brain Tumor M F Heart Problems M F Liver Problems

M F Arthritis M F Cancer M F High Blood Pressure M F Thyroid Problems

M F Asthma M F Diabetes M F Joint Implants M F Tuberculosis(TB)

Other (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are You Under Pain Management? YES or NO Pain Clinic Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been tested for SLEEP APNEA? YES or NO If yes, were you prescribed a CPAP/BIPAP machine to wear? YES or NO**

**Do you have Advance Directives? YES or NO**

 **EMAIL ADDRESS - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Appointments missed or not cancelled with at least 24 hours notice will be subject to a $25 fee. This fee is the responsibility of the patient or guarantor. Please sign stating you understand this**

**SIGNATURE OF PATIENT**

**OR LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your insurance is a personal contract between you and your insurance company. If you would like for us to file your insurance claim for you **(provided it is one that we contract with)** please provide your card to the Patient Coordinator. If you have questions as to whether or not we are in network with your insurance, please call your insurance company. **Without your card or proof of insurance, your claims will not be filed and payment is due in full on the day services are rendered, unless other arrangements have been made in advance with our office.**

\*\***\* IF YOUR INSURANCE REQUIRES REFERRALS FOR YOU TO SEE A SPECIALIST (AND WE ARE A SPECIALIST) THEN IT IS YOUR RESPONSIBILITY TO GET THE REFERRAL TAKEN CARE OF PRIOR TO YOUR VISIT. IF A REFERRAL IS NOT SUBMITTED TO YOUR INSURANCE COMPANY BY YOUR PRIMARY CARE PHYSICIAN, THEN YOUR VISIT WILL BE DENIED. *ANYONE BEING SEEN WITHOUT THE PROPER REFERRAL & THEIR INSURANCE REQUIRES ONE, MUST BE SELF PAY ON THE DAY THAT THEY ARE SEEN.* YOUR PRIMARY CARE DOCTOR IS THE ONE WHO SUBMITS THE REFERRAL REQUEST TO YOUR INSURANCE BEFORE YOU COME TO SEE US.**

**\*\*\* IF YOU DO NOT HAVE INSURANCE, PAYMENT IS DUE IN FULL ON DATE SEEN.**

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| ***INSURANCE ASSIGNMENT OF BENEFITS:*** **PODIATRIC SERVICES MAY NOT BE CONSIDERED TO BE MEDICALLY NECESSARY BY YOUR INSURANCE COMPANY AND THEREFORE MAY NOT BE REIMBURSED AS A COVERED EXPENSE** |

By signing below you authorize the doctor to release such private medical information as is necessary to file your insurance claim with your insurance company and **authorize payment of insurance benefits be made to Pinehurst Foot Specialist, PA.** It is the patient’s responsibility to pay for services rendered regardless of your insurance’s determination to the necessity of that service. Podiatric services may not be covered for one of the following reasons:

* Routine foot care (trimming nails, corns, calluses, etc) is not a covered service without a medical necessity.(Necessity is not back problems or the inability to reach your feet -**NON COVERED ROUTINE FOOT CARE WILL BE $50)**
* If a covered service is performed more often than what insurance allows, it will not be covered.
* If a patient receives a covered foot care service that is related to a systemic problem, and the patient has not seen their medical doctor within the last 6 months, then insurance will not cover the services.
* Supplies such as tape, gauze, pads for toes/feet, clear nails, and other creams are not covered by insurance.
* **Custom Molded ORTHOTICS are not covered by Medicare/ Medicaid.**
* **Over the counter ORTHOTICS are not covered by any insurance.**
* **Custom Molded ORTHOTICS are only covered by a few commercial insurance.**

It is an Insurance regulation that our office informs you of this information and gets waivers for certain non-covered services.

*Your signature below indicates that you have read and understand the information* *above****.***

**SIGNATURE OF PATIENT**

**OR LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| ***NOTICE OF PRIVACY PRACTICES*** |

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

**SIGNATURE OF PATIENT**

**OR LEGAL GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Under certain circumstances, we may not be able to reach you by phone or you may not be able to call for yourself regarding an appointment, prescription, etc. Should this happen, we would like to know the following:

MAY WE: Leave a message on your answering machine **at home?** \_\_\_ YES \_\_\_ NO **At work?** \_\_\_YES \_\_\_No

 Discuss your medical condition with any member of your family or allow them to pick up prescriptions or

 paperwork for you? \_\_\_ YES \_\_\_ NO **IF YES, WHOM?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_