



PODIATRIC REGISTRATION AND HISTORY

Steven Stanton, D.P.M.

Family Foot Care

...Your Feet's Best Friend

7087 Highway 6 North, Houston, Texas 77095

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

Can we leave a message at this number? Yes No

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a Podiatrist before? Yes No

If yes, please list.

Name _____

Last Visit _____

Is there any personal or family history of diabetes? Yes No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

- Ankle Pain Yes No
- Athlete's Foot Yes No
- Bunions Yes No
- Corns and Calluses Yes No
- Cramps or Numbness in Feet or Legs Yes No
- Flat Feet Yes No
- Foot or Leg Cramps Yes No
- Heel Pain Yes No
- Ingrown Toenails Yes No
- Plantar Warts Yes No
- Swelling in Ankles or Feet Yes No
- Tired Feet Yes No

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Ear Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____
 Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No
 If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

 Pharmacy Name(s) _____
 Pharmacy Phone(s) _____
 Do you take oral contraceptives? Yes No

ALLERGIES

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Therapy | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Demerol | |
| <input type="checkbox"/> Iodine | |
| Other _____ | |

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

Written Acknowledgement of Receipt of Cy-Fair Family Foot Care Joint Notice of Privacy Practices

By signing below, you acknowledge receiving the Cy-Fair Family Foot Care Joint Notice of Privacy Practices (Notice). The Notice explains how Cy-Fair Family Foot care may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

Cy-Fair Family Foot Care reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be available at our office and on our website at www.houstonpodiatry.com. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register for healthcare services at our office, we will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.

If you have any questions about the Notice, please contact the Cy-Fair Family Foot Care Privacy Officer. Contact information is located in the Notice.

Printed Name of Patient _____

Patient's Date of Birth _____

Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Date _____