Coral Gables Podiatry

Date: _____

PATIENT REGISTRATION

Patient Information			
Last Name	First Name	M.I.	M ☐ F ☐
By what name do you prefer to be addressed?			Single Married Other
Patient's Address			
City	State	Zip	
Home Phone	Work Phone	E-mail	
SSN	Date of Birth	Age	
Emergency Contact	Relationship	Phone	
Reason for Visit:			

Insurance Information	
Name of Insurance	Policy Number
Name of Insured (if other than self)	Date of Birth
Relationship with Patient: ☐ Self ☐ Child ☐ Spouse ☐ Parent ☐ Other	
Employer / Address / Phone Number	

Referral
Referred by: ☐ Friend/Relative ☐ Web Search ☐ Insurance ☐ Returning Patient
☐ Other: _____

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List all medications you are taking: (including herbs, vitamins & over the counter medications):

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

Medical Conditions

Have you ever had any of the following:
(Select all that apply)

Y N Asthma
Y N Anemia
Y N Arthritis
Y N Artificial Heart
Y N Back Problems
Y N Bleed Easily
Y N Cancer
Y N Chemical Dependency
Y N Chest Pain
Y N Circulatory Problems
Y N Diabetes
Y N Epilepsy
Y N Fibromyalgia
Y N Gout
Y N Heart Disease
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N HIV
Y N Kidney Problems
Y N Leg Cramps
Y N Liver Disease
Y N Lung/Respiratory
Y N Mental illness
Y N Thyroid Problems

Surgeries

Have you had any surgeries? Y N
Please list:
_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

Social History

Do you Smoke? Yes No

Are you a past smoker? Yes No

How much/often?_____ packs.

Years Smoked? .

Drink Alcohol?: Yes No
How often: _____

Recreational Drugs? Yes No
What:_____

Pregnant or possibly pregnant? Yes No

Family Medical History

Have you or someone in your family had any of the following…..
High Blood Presure:_____
Heart Disease:_____
Cancer:_____
Type:_____
Diabetes:_____
Thyroid Problems:_____
Depression:_____
Anxiety:_____
Bipolar Disorder:_____
Schizophrenia:_____

Height:

Weight:

Allergies:_____ _____
_____ _____
_____ _____
_____

I certify that the information contained in this form is correct to the best of my knowledge. In addition, I authorize the disclosure of any medical information necessary to process the request for payment of treatments or operations. I authorize payment of medical benefits to Coral Gables Podiatry Center, the provider or service providers. I hereby authorize the provider and anyone with whom he may designate as his assistant (s), to administer such treatments and procedures that in his opinion are considered necessary. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles, and non-covered services. I understand that the card I pay with today will be kept on file for future balances. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow Coral Gables Podiatry Center to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to Coral Gables Podiatry Center.

Patient Signature _____ **Date** _____

If minor, parent or guardians name _____

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Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that: I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ……..……..

Printed Name of Individual or Legal Representative ……..……... Witness…….. Date: ……

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify) _____

_____ _____

HIPAA Officer Date