

WELCOME TO FOOT CARE ASSOCIATES

Surgery and Diseases of the Foot & Ankle – Sports Medicine – Wound Care

CONFIDENTIAL PATIENT REGISTRATION

NAME OF PATIENT _____ AGE _____ DATE OF BIRTH _____ Sex: **M** **F** Today's Date _____

HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL OR PAGER # _____

PATIENT SOCIAL SEC. # _____ E-MAIL _____ DRIVER LIC. # _____

PATIENT EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE () _____
CITY _____ STATE _____ ZIP _____

SPOUSE / PARENT / GUARDIAN NAME _____ MARITAL STATUS: M S D W SEP.

SPOUSE / PARENT / GUARDIAN SOC. SEC. NO. _____

SPOUSE EMPLOYER _____ SPOUSE OCCUPATION _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY NOTIFY (NAME) _____ **PHONE NUMBER** _____

REFERRED BY _____ HMO / PPO BOOK YELLOW PAGES INTERNET

INSURANCE

PRIMARY INSURANCE:

Insurance Co. _____ Policy # _____ Group # _____

Name of Insured _____ Insured Work # _____ Insured Birth date _____

Relationship to Patient _____ Insured Soc. Sec. # _____

SECONDARY INSURANCE:

Insurance Co. _____ Policy # _____ Group # _____

Name of Insured _____ Insured Work # _____ Insured Birth date _____

Relationship to Patient _____ Insured Soc. Sec. # _____

CONSENTS

- I hereby give FOOT CARE ASSOCIATES – Dr. Sloan Gordon permission to examine and treat my feet. I agree to be responsible for all medical bills.
- In consideration of services rendered, I hereby irrevocably assign and transfer to Dr. Sloan Gordon, for myself and my dependents, all right, title and interest in the benefits payable for services rendered by the doctors provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for the purpose of granting Dr. Sloan Gordon an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for this treatment but shall not be construed to be an obligation of Dr. Sloan Gordon to pursue any such right of recovery.
- I hereby authorize and direct all insurance company(ies) under which I am insured to pay directly to the doctors all benefits due under said policy(ies) by reason of services rendered therein. I will pay Dr. Sloan Gordon for all charges incurred or alternatively, for all charges in excess of the sums actually paid by said policy(ies).
- I also irrevocably assign to Dr. Sloan Gordon all right, title and interest in benefits payable out of any third party action against any other person, entity or insurance company, under which I may be entitled to recover.
- Each person signing this consent is financially responsible for charges not collected by this assignment.

Patient, Parent or Guardian's Signature X _____ Date _____

MEDICAL

EXPLAIN YOUR PROBLEM? _____ HOW LONG? _____

PAIN INTENSITY (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe) | ANY TREATMENT? Anti Inflammatory Phys. Therapy Injection

STUDIES PERFORMED? MRI CAT SCAN X-Rays Nerve Study Bone Scan HEIGHT _____ WEIGHT _____

ANY PREVIOUS INJURIES, AUTO ACCIDENTS, WORK INJURIES? _____

ANY ADJUSTERS, LAWYERS OR OTHER DOCTORS INVOLVED? _____

MEDICINES YOU TAKE _____

DO YOU HAVE ANY ALLERGIES? [] None Known LATEX / RUBBER DYES / IODINE CODEINE LOCAL ANESTHETICS PENICILLIN ASPIRIN SULFA NOVOCAINE TAPE FOODS OTHER _____

FAMILY DOCTOR / PCP _____ DATE OF LAST EXAM _____

NOTE: IF MY HEALTH OR MEDICATION CHANGES, I WILL NOTIFY THE DOCTOR AT MY NEXT VISIT.

PATIENT HISTORY: Do you have or have you ever had: circle or [x]

- ANEMIA ARTHRITIS ASTHMA ANKLE/LEG SWELLING BLOOD PROBLEM BLOOD TRANSFUSION BRONCHITIS BRUISE EASILY CANCER CHEST PAIN COUNSELING DIABETES EMPHYSEMA EPILEPSY / SEIZURE FOOT ULCER GOUT HEARING PROBLEM HEART MURMUR HEART TROUBLE HEPATITIS HIGH BLOOD PRESSURE HIV / AIDS KIDNEY PROBLEM LEG CRAMPS LIVER PROBLEM LOW BACK PAIN LOW BLOOD SUGAR PASSING OUT PHLEBITIS / CALF PAIN POOR CIRCULATION PROLONGED BLEEDING PRONE TO INFECTION PSYCHIATRIC CARE RHEUMATIC FEVER SHORT OF BREATH SICKLE CELL STOMACH ULCER STROKE THYROID PROBLEM TUBERCULOSIS (TB) UNEQUAL LEG LENGTH VARICOSE VEINS WEAK ANKLES [] OTHER

FEMALES: Any chance you might be pregnant? [] Yes [] No BODY PIERCINGS OR TATTOOS? [] Yes [] No

PREVIOUS HOSPITALIZATION / SURGERY / ILLNESS [] No [] Yes (Explain)

Table with 2 columns: Year, Illness / Operation / Hospitalization / Complications

- FAMILY HISTORY: AIDS / HIV ARTHRITIS ALCOHOLISM BLEEDER CANCER DIABETES HEART DISEASE HEPATITIS HIGH CHOLESTEROL HYPERTENSION MIGRANES MENTAL ILLNESS OSTEOPOROSIS STROKES OTHER

SOCIAL HISTORY Do you smoke? Cigarettes / Pipe / Cigar Amount / day # years Quit date Do you drink alcohol? Type Amount/day # years Quit date Recreational drugs? Type Amount/day # years Quit date

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signed Date INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signed Date

I plan to pay today by: [] Cash [] Check [] Visa [] Mastercard [] Amex [] Discover

We are sorry, but we cannot accept a credit card for charges of less than \$25.00. Thank you. ☺