PATIENT REGISTRATION FORM

(PLEASE FILL OUT COMPLETELY)

****

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #'S: HOME: (____) _____ - _____ WORK: (____) _____ - _____

CELL: (_____) _____ - _____ OTHER: (_____) _____ - _____

E-MAIL ADDRESS: _____ FAX: (_____) _____ - _____

BIRTHDATE: ____ / ____ /____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: (CIRCLE) MARRIED SINGLE WIDOWED SEPARATED DIVORCED

ARE YOU A STUDENT? YES: ____ NO: ____ IF YES: FULL TIME: ___ PART TIME: ____

EMPLOYER NAME: _____ RETIRED: YES: ____ NO: ____

MEDICAL DOCTOR'S NAME: _____ CITY/CLINIC: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

DOCTOR☐ PATIENT☐ YELLOW PAGES☐ DIRECTORY☐ AD☐ OTHER: _____

NAME: _____

EMERGENCY CONTACT: NAME: _____

CONTACT #: _____ RELATIONSHIP TO PATIENT: _____

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 choose, and understand the Notice. INITIAL:_____

DATE: _____ /_____ /_____ **PATIENT SIGNATURE**: _____

PLEASE HAVE INSURANCE CARDS AVAILABLE SO WE CAN MAKE COPIES.

IT IS YOUR RESPONSIBILITY TO NOTIFY THE OFFICE STAFF IF YOUR INSURANCE OR ANY OF YOUR PERSONAL INFORMATION CHANGES.

Chapel Hill Foot and Ankle Associates, P.A.

NAME_____ DATE_____

DATE OF BIRTH_____ AGE____ SEX_____ RACE_____ PHONE (H)_____ (C)_____

MEDICAL DOCTOR_____ REFERRING PHYSICIAN_____

CHIEF COMPLAINT_____

PLEASE TELL US ABOUT YOUR CHIEF COMPLAINT_____

_____

_____

PAST MEDICAL HISTORY

1) HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

HEART TROUBLE	YES	NO	JOINT PAIN	YES	NO	GASTRIC REFLUX (GERD)	YES	NO
HIGH CHOLESTEROL	YES	NO	GOUT	YES	NO	STROKE/ TIA's	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ULCERS	YES	NO	BLOOD CLOTS	YES	NO
DIABETES	YES	NO	THYROID PROBLEMS	YES	NO	CANCER	YES	NO
DELAYED HEALING	YES	NO	KIDNEY/LIVER	YES	NO	OSTEOPOROSIS	YES	NO
PROLONGED BLEEDING	YES	NO	SEIZURES	YES	NO	DEPRESSION/ANXIETY	YES	NO
ANEMIA	YES	NO	BREATHING PROBLEMS	YES	NO	LOW BACK PAIN	YES	NO
PHLEBITIS	YES	NO	HEPATITIS/HIV	YES	NO	OTHER _____		

2) DO YOU HAVE CRAMPING IN YOUR FEET/LEGS WHEN YOU WALK? YES NO

IS THIS PAIN RELIEVED WITH REST? YES NO HOW FAR CAN YOU WALK UNTIL YOU EXPERIENCE CRAMPING?_____

3) LIST ALL SURGERIES:_____

_____

_____

4) LIST ALL MEDICATIONS THAT YOU TAKE (PRESCRIPTION, NONPRESCRIPTION, HERBAL AND VITAMINS)

MEDICINE	DOSE	#/DAY	MEDICINE	DOSE	#/DAY

_____

_____

_____

_____

_____

_____

_____

5)ANY ALLERGIC REACTIONS TO MEDICATIONS, FOODS, TAPE, LATEX, OR BETADINE?_____

_____

6) HAS ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL PROBLEMS?

DIABETES	YES NO	KIDNEY DISEASE	YES NO	HIGH BLOOD PRESSURE	YES NO
BLEEDING PROBLEMS	YES NO	ARTHRITIS	YES NO	CANCER	YES NO

OTHER_____

OCCUPATION_____ MARITAL STATUS_____ CHILDREN_____ PREGNANT YES NO

DO YOU SMOKE? YES NO HOW MUCH DO YOU SMOKE IN A DAY?_____ HOW LONG HAVE YOU BEEN SMOKING?_____

ALCOHOL? YES NO AMOUNT/DAY_____

WHAT SPORTS/ACTIVITIES DO YOU LIKE TO PARTICIPATE IN?_____

REVIEW OF SYSTEMS: DO YOU AT PRESENT HAVE ANY OF THE FOLLOWING PROBLEMS?

FEVER/CHILLS	YES NO	WEIGHT LOSS	YES NO	EYE DISEASE	YES NO	SORE THROAT	YES NO
SWOLLEN NECK GLANDS	YES NO	COUGH	YE S NO	SHORTNESS OF BREATH	YES NO	BLADDER INFECTION	YES NO
BURNING WITH URINATION	YES NO	DIFFICULTY WITH URINATION	YES NO	ANGINA/CHEST PAIN	YES NO	IRREGULAR HEARTBEAT	YES NO
POOR CIRCULATION	YES NO	SWELLING OF LEGS	YES NO	VARICOSE VEINS	YES NO	LEG/FOOT ULCERS	YES NO
ANXIETY/DEPRESSION	YES NO	MOOD DISTURBANCE	YES NO	NUMBNESS/TINGLING	YES NO	PARALYSIS	YES NO
SEIZURES	YES NO	JOINT PAIN	YES NO	ANEMIA	YES NO	BLEED EASILY	YES NO
BRUISE EASILY	YES NO	HEAT INTOLERANCE	YES NO	RASH	YES NO	BLACK/TAR-LIKE STOOL	YES NO
BLOODY STOOLS	YES NO	DIARRHEA	YES NO	NAUSEA/VOMITING	YES NO		

OTHER_____

7) IS THERE ANYTHING ELSE YOU FEEL YOUR PHYSICIANS SHOULD KNOW ABOUT YOU?_____

_____

_____

CHAPEL HILL FOOT AND ANKLE ASSOC., P.A.

1506 E. Franklin Street
Suite 104
Chapel Hill, NC 27514

Phone: (919)960-8858
Fax: (919)960-2882

NOTICE TO OUR PATIENTS

Although you have obtained the proper authorization from your primary care physician, if your managed care insurance company determines that a particular service is "**not medically necessary**" , the company will not pay for the visit and the patient is responsible for any amount due on the day that the service is rendered.

Services that are considered non-covered may include the following:

Trimming of toenails, corns, and calluses
(this includes routine foot care for the diabetic patient that requests nails, corns and calluses trimmed.)

The treatment of flat feet, orthotics, arch supports, molded shoes, removable casts, and other foot care items including padding supplies.

For a complete listing, please consult your member booklet, or telephone your insurance company.

BENEFICIARY AGREEMENT:
I have been notified by this office that my managed care insurance company may deny payment for the services received. I agree to be personally responsible for payment on the day that the service is given.

_____ _____

PATIENT SIGNATURE DATE SIGNED

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 choose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature