### PATIENT REGISTRATION FORM

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) MARRIEI	O SINGLE WIDOWED SEPA	RATED DIVORCED
ARE YOU A STUDENT? YES: NO: _	IF YES: FULL TIME: _	PART TIME:
EMPLOYER NAME:	RETIRED:	YES: NO:
MEDICAL DOCTOR'S NAME:	CITY/CLINIC	D:
HOW WERE YOU REDOCTOR□ PATIENT□ YELLOW PAGENAME:		OTHER:
EMERGENCY CONTACT: NAME:		
CONTACT #:R	ELATIONSHIP TO PATIEN	Γ:
I acknowledge that I was provided a copy of or had the opportunity to read if I so choose,  DATE://PATIEN	and understand the Notice. IN	NITIAL:

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.

DATE OF BIRTH		AGE	_ SEX	RACE	РНО	NE (H)	(C)		
CHIEF CON ADL AUNIT				REFERRING	PHYS	ICIAN			
THIEF COMPLAINT									
PLEASE TELL US ABOU									
PAST MEDICAL HISTOR	 <u>RY</u>								
1) HAVE YOU EVER HAD AN	Y OF THE	FOLLOW	ING CONDIT	IONS?					
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 PRESS	URE 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 BLEED	ING 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 IS THIS PAIN RELIE 3) LIST ALL SURGERIES:	EVED WIT	H REST?	YES NO	HOW FAR C			U EXPERIENCE CRAMPING	?	
4) LIST ALL MEDICATIONS T	HAT VOLL	TAKE (DI	RESCRIPTION	NONPRESCRIPTION		AL AND VITAMINS)			
MEDICINE	DOSE	TAKE (T	#/DAY	, NOW RESCRIPTION,	ILINDA	MEDICINE		'DAY	

FEVER/CHILLS  YES NO WEIGHT LOSS  YES NO EYE DISEASE  YES NO SORE THROAT  YES NO SHORTNESS OF BREATH YES NO BLADDER INFECTION  BURNING WITH URINATION YES NO DIFFICULTY WITH URINATION YES NO ANGINA/CHEST PAIN YES NO IRREGULAR HEARTBEAT  POOR CIRCULATION  YES NO SWELLING OF LEGS  YES NO VARICOSE VEINS  YES NO PARALYSIS  YES NO BLEED EASILY  YES NO BLEED EASILY  YES NO BLEED EASILY	E YES NO	LOOD PRESSURE	HIGH BI		NO	YES	KIDNEY DISEASE	10	YES N		DIABETES
MARITAL STATUS CHILDREN PREGNANT 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 SWOLLEN NECK GLANDS YES NO COUGH YES NO SHORTNESS OF BREATH YES NO BLADDER INFECTION YES BURNING WITH URINATION YES NO DIFFICULTY WITH URINATION YES NO ANGINA/CHEST PAIN YES NO IRREGULAR HEART BEAT YEPOOR CIRCULATION YES NO SWELLING OF LEGS YES NO VARICOSE VEINS YES NO LEG/FOOT ULCERS YES ANXIETY/DEPRESSION YES NO MOOD DISTURBANCE YES NO NUMBNESS/TINGLING YES NO BLEED EASILY YES SEIZURES YES NO JOINT PAIN YES NO ANEMIA YES NO BLEED EASILY YES	YES NO	3	CANCER		NO	YES	ARTHRITIS	0	YES N	EMS	BLEEDING PROBL
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POOR CIRCULATION YES NO SWELLING OF LEGS YES NO VARICOSE VEINS YES NO LEG/FOOT ULCERS YES NO NUMBNESS/TINGLING YES NO PARALYSIS YES USE NO JOINT PAIN YES NO ANEMIA YES NO BLEED EASILY YES NO PARALYSIS YES NO PA	DER INFECTION YES	NO BLADDER	EATH YES	HORTNESS OF BREA	NO	YE S	DUGH	COUGH	NO	YES	OLLEN NECK GLANDS
ANXIETY/DEPRESSION YES NO MOOD DISTURBANCE YES NO NUMBNESS/TINGLING YES NO PARALYSIS Y SEIZURES YES NO JOINT PAIN YES NO ANEMIA YES NO BLEED EASILY Y	GULAR HEARTBEAT YES	NO IRREGUL	IN YES	NGINA/CHEST PAIN	NO .	N YES	FFICULTY WITH URINATION	DIFFICULT	NO	YES	RNING WITH URINATION
SEIZURES YES NO JOINT PAIN YES NO ANEMIA YES NO BLEED EASILY Y	FOOT ULCERS YES	NO LEG/FOO	YES	ARICOSE VEINS	NO	YES	VELLING OF LEGS	SWELLING	NO	YES	OR CIRCULATION
	ALYSIS YES	NO PARALYS	ING YES	NUMBNESS/TINGLIN	NO	YES	OOD DISTURBANCE	MOOD DIS	NO	YES	IXIETY/DEPRESSION
DRIVING FACULY VEC. NO DEAT INTO FRANCE VEC. NO DACU VEC. NO DEACH/TABLUM CTOOL N	ED EASILY YES	NO BLEED EA	YES	ANEMIA	NO	YES	INT PAIN	JOINT PAI	NO	YES	IZURES
BRUISE EASILY YES NO HEAT INTOLERANCE YES NO RASH YES NO BLACK/TAR-LIKE STOOL Y	CK/TAR-LIKE STOOL YES	NO BLACK/T	YES	RASH	NO	YES	EAT INTOLERANCE	HEAT INTO	NO	YES	UISE EASILY
BLOODY STOOLS YES NO DIARRHEA YES NO NAUSEA/VOMITING YES NO		NO	G YES	NAUSEA/VOMITING	NO	YES	ARRHEA	DIARRHEA	NO	YES	OODY STOOLS
OTHER											'HER
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 <u>may</u> 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 ma	inaged care insurance company
may deny payment for the services received.	I agree to be personally responsi-
ble 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	
December Authorized December (15 and Backley)		
Parent or Authorized Representative (if applicable)		
Signature		