NEW PATIENT REGISTRATION FORM

Today's Date ____/____/____ **Doctor** (please circle one) **Paul Ross, DPM** **Michael Matthews, DPM**

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.
Street Address	City,State		Zip Code
Home Phone # ( ) -	Cell Phone # ( ) -	E-mail Address	

Birth Date	Social Security Number	Marital Status	Sex
/ /		☐Single ☐Married ☐ Separated ☐Widowed ☐Divorced	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured Employer

Insured Employer Address

Please indicate primary insurance	Address of primary insurance carrier			
Insured Name	Insured DOB	Insured ID	Policy Group #	Effective Date

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER

Please indicate secondary insurance	Address of secondary insurance carrier			
Insured Name	Insured DOB	Insured ID	Policy Group #	Effective Date

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER

Referred to The Podiatry Center by:
(Please choose one and specify)

- ❑ Doctor_____
- ❑ Family _____
- ❑ Friend _____
- ❑ Insurance _____
- ❑ Internet _____
- ❑ Other _____

MEDICAL HISTORY

ALLERGIES **(LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS**

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin
☐ Other(s)			

MEDICATIONS ***(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)***

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	**HOW LONG?**	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

☐ Surgery:	☐ Custom Orthotics	☐ Oral Medications: Which?	☐ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name		Phone Number ( ) -	
Street Address	City	State	Zip Code
Have you ever been put to sleep for surgery? ☐ Yes ☐ No			

SHOE SIZE	**HEIGHT**		**WEIGHT**
DO YOU DRINK?	☐ NO	☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO	☐ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Cancer: Type	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes: Type I or II (Please circle one)	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Psychiatric/Psychological Care Type:	☐ Yes	☐ No
Heart (Surgery, Disease, Attack, Murmur)	☐ Yes	☐ No	Seasonal allergies	☐ Yes	☐ No
Hepatitis Type	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Name: _____

Signature: _____ **Date:**

REGISTRATION FORM

Today's Date ____/____/____ Doctor (please circle one) **Paul Ross, DPM** **Michael Matthews, DPM**

PATIENT INFORMATION

Patient's Last Name	First	Middle	Birth Date
			/ /

DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I Decline to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ I Decline to Report

Preferred Language ☐ English ☐ Spanish ☐ Other

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Osco ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other

Address: _____

City: _____State: _____Zip Code: _____

Phone Number: _____ Fax Number: _____

☐ This is a mail order pharmacy

☐ I do not have a preferred pharmacy

I authorize The Podiatry Center and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ THE FOLLOWING:

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:
To The Podiatry Center

X _____ **Date:** _____

Financial Policy

Thank you for choosing The Podiatry Center as your healthcare provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing department at (847) 627-4920.

Your clear understanding of our Financial Policy is important to our professional relationship:

- We are happy to bill your insurance company directly; however, we must have a copy of your insurance card (Front and Back).
- If you do not have your insurance information with you,full payment is due at the time of service. We accept cash, check, Visa, Mastercard, American Express, Discover and Care Credit.
- All patients must complete our “Patient Registration Forms” and other related forms.
- Please notify us immediately of any change in your insurance coverage.
- If your insurance requires a referral, you must provide it at the time of service. You are fully responsible for the services if you did not provide a referral at the time of service.

Cancellation Policy

We require 24 hours notice when cancelling and/or rescheduling an appointment.

Self Pay

We expect payment at the time of service unless prior arrangements have been made.

Medicare

We accept Medicare assignments. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare we will advise you of any non-covered charge prior to the service being provided.

HMO/PPO

Co-payments are due at the time of service. We are members of most major insurance plans, but not all plans. Patients are responsible for verifying that we are providers for an insurance plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our Physician is in their plan. The patient is responsible for any non-covered charges by their insurance company.

Workers Compensation

If you are here because of a work-related injury, we will require information regarding both health insurance and your employer's Workers Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Workers Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's Human Resources office should be able to assist you with obtaining this information.) If payment is not received from these third parties within 90 days, you may be billed directly.

Hospital and Surgery Center Charges

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at The Podiatry Center may have a financial interest in a surgery center where you will be having your surgery.

Financial Agreement

I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash.

UCR (Usual and Customary Rates)

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determinations of UCR rates.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.

If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.

Retail Products

In order to provide the best treatment possible, some products that the doctor prescribes may not be covered by your insurance and are deemed as retail. They are subject to state taxes and we are able to provide you with a detailed receipt.

PATIENT NAME: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:
To The Podiatry Center
X _____ **Date:** _____

HIPAA AUTHORIZATION:
Necessary to process claims
X _____ **Date:** _____

COMMUNICATION AUTHORIZATION:
I authorize The Podiatry Center to contact me via phone, text, fax, mail and email
X _____ **Date:** _____