PATIENT REGISTRATION

Your Doctor: (please circle one) Paul Ross, DPM Michael Matthews, DPM

PATIENT INFORMATION

Mr. / Mrs. / Ms. / Miss.	Patient's Last Name:	First Name, Middle Initial:	☐ Male ☐ Female	Birth Date:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Street Address:	City:	State:	Zipcode:

Cell Phone:	E-mail Address:	Social Security Number:

Emergency Contact:	**Relationship:**	**Phone:**

DEMOGRAPHICS (FOR GOVERNMENT STATISTICAL ANALYSIS)

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Decline to Report

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Declined to Report

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other:

INSURANCE INFORMATION

Please Indicate Primary Insurance Carrier:	Member ID:	Group:	
Policy Holder Name:	Policy Holder DOB:	☐ Self ☐ Spouse ☐ Child ☐ Other	

Insurance Type: ☐ HMO ☐ POS ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ WC ☐ AUTO

Please Indicate Secondary Insurance Carrier:	Member ID:	Group:	
Policy Holder Name:	Policy Holder DOB:	☐ Self ☐ Spouse ☐ Child ☐ Other	

Insurance Type: ☐ HMO ☐ POS ☐ PPO ☐ MEDICARE ☐ MEDICAID

REFERRED BY *(please select one and specify)*

☐ Zocdoc ☐ Doctor.com ☐ Website ☐ Doctor ☐ Family ☐ Friend ☐ Internet ☐ Insurance

☐ Other Please list name:

PREFERRED PHARMACY & PRESCRIPTION INFORMATION

☐ Mail Order Pharmacy ☐ CVS ☐ Target ☐ Walmart ☐ Walgreens ☐ Other:

Address:	City:	State:	Zipcode:	Phone:

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 HAVE READ THE ABOVE STATEMENT AND CONSENT TO THE PODIATRY CENTER OBTAINING MY EXTERNAL PRESCRIPTION HISTORY: (if patient is a minor, please have guarantor sign)

Please sign: _____ **Date:** _____

OUR CANCELLATION POLICY

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

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OUR INSURANCE AND FINANCIAL POLICIES

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

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 (301) 656-6055.

Please Note:

- We will bill your insurance company directly; however, we need a copy of your insurance card (front and back) on file. ***Please notify us immediately of any changes in your insurance coverage.*
- If your insurance requires a referral, you must provide it at the time of service. Insurance plans will require you to reschedule your appointment if no referral is presented or they will deny your claim. If you choose to be seen, you will be responsible for full payment at the time of service.
- If we do not have your insurance information on file, full payment is due at the time of service. We accept cash, check, Care Credit, and all major credit cards.
- All Patient Registration Forms must be completed in full at the time of service.
- All Co-payments are due at the time of service. We are members of most insurance plans. Patients are responsible for verifying that we are providers under your individual plan.
- We are committed to providing the best treatment possible for our patients and charge what is usual and customary for our area.

MEDICARE

We accept Medicare assignments. As a Medicare patient, you are responsible for your annual deductible. Some services and supplies are not covered by Medicare. Our office will advise you of any non-covered charges prior to the service being provided.

HMO / PPO

If you have an HMO plan, we will bill your insurance if we have a valid referral on file. If you have a PPO plan, you will be responsible for your deductible, co-payments, and co-insurance. You will be responsible for any non-covered charges by your insurance plan/carrier.

**** SELF PAY PATIENTS WILL BE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE ****

WORKER'S COMPENSATION

If you are here due to a work-related injury, we require both your health insurance and your Employer's Worker's Compensation insurance information. Before seeing the doctor, we require a letter or statement of authorization from your Worker's Compensation carrier, including your claim number, adjustor's name, phone number, and address. (Your employer should be able to assist you in obtaining this information). Please note, if we do not receive payment from these third parties within 90 days, you may be billed directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event you undergo surgery in a hospital or surgery center, a separate fee will be charged by the facility. Your physician at The Podiatry Center may have a financial interest in a surgery center where you will be scheduled for surgery.

RETAIL PRODUCTS

In order to provide the best treatment possible, some products may be prescribed by your doctor that are covered by insurance. These products are deemed as retail and are subject to state taxes. We are able to provide a detailed receipt for any purchase.

FINANCIAL AGREEMENT

I understand that I am financially responsible for 1.) all charges not covered by my insurance carrier or other responsible party and 2.) payments not received by my insurance or responsible party within 90 days. I guarantee full payment by my credit card, cash, or check to satisfy all charges I incur during my treatment.

I understand that I must submit all information necessary to bill my insurance and ensure payment for the services rendered to me, including but not limited to, insurance details and referral if required.

I authorize The Podiatry Center to share my information with my insurance carrier for the purpose of processing my claims.

I authorize The Podiatry Center to contact me via: ☐ Cell Phone ☐ Text ☐ Email

☐ **It is ok to leave a message**

PATIENT NAME: (please print)

Guarantor Name: (if applicable)

PLEASE SIGN: (above listed guarantor, please sign if patient is a minor) DATE:

Thank you for completing the registration and welcome to our office!

MEDICAL HISTORY

Your Doctor: (please circle one) Paul Ross, DPM Michael Matthews, DPM

Patient Name:	**Birth Date:**
Please explain the current pain or issue you are here for today:	
How long have you experienced this issue?	
What previous treatment(s) have you had for your foot/ankle? (eg. surgery, custom orthotics, oral medications, cortisone shots, etc.)	

Shoe Size:	**Height:**	**Weight:**	

Do you drink alcohol:
☐ Yes, # of drinks per week _____ ☐ No

Do you smoke:
☐ Yes, # of packs per week _____ ☐ No

ALLERGIES (List known allergies or reactions to drugs/medications)

☐ Penicillin ☐ Sulfa ☐ Local Anesthetic ☐ Anti-inflammatory Medication
☐ Codeine ☐ Tape ☐ Nausea from Anesthesia ☐ Iodine on Skin
☐ Others: _____

MEDICATIONS (Please list current medications that you are currently taking: Prescription and Over-the-Counter)

MEDICATION	DOSE	MEDICATION	DOSE

FAMILY PHYSICIAN INFORMATION

Name:	Phone:		
Address:	City:	State:	Zipcode:

Please indicate which of the following you have had or are currently experiencing. Check Yes or No to each item.

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artifical Joints (hip, knee, etc)	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Cancer: Type	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes: Type I or II	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Psychiatric/Psychological:	☐ Yes	☐ No
Hepatitis: Type	☐ Yes	☐ No	Seasonal Allergies	☐ Yes	☐ No
Heart (Surgery, Disease, Attack, Murmur)	☐ 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, I give 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 Signature: (guarantor signature if patient is a minor) _____ **Date:** _____