PODIATRIC REGISTRATION AND HISTORY

Personal Data **Date**: _____

Patient Name: _____ DOB: _____ Age: _____

Nick Name/Preferred Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Best Contact Number: _____ Alternate Number: _____

Responsible Party (If under 18 years of Age): _____ Relationship _____

Patient SS#: _____

Gender: ☐ Male ☐ Female ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced** ☐ **Single**

Ethnicity: ☐ Hawaiian ☐ Native American ☐ Hispanic ☐ Caucasian ☐ African American ☐ Asian

☐ Employed-Occupation: _____ ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

E-Mail: _____
If not providing e-mail: ☐ No E-mail ☐ Decline to Provide E-mail

Family Physician: _____ **Last Visit Date**: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____

Primary Insurance (Please Provide Office with the most updated/accurate Insurance Card(s):

Name of Insured: _____ DOB: _____ Relationship: _____

Secondary Insurance:

Name of Insured: _____ DOB: _____ Relationship: _____

Have you had the following: Flu Vaccine: Yes No If No Reason: Declined Unavailable Allergic
65 years and older: Pneumonia: Yes No Do you have a Living Will: Yes No

Podiatric History:
IF Treated by a Podiatrist in Past: What Where You Treated For, By Whom, and Last Visit:
_____

Activities in Which You Participate: (Please list and indicate frequency. Examples: Sports, Hiking, Yoga, etc): _____

Reason for Todays Visit: _____

Smoker: ☐ Current ☐ Former ☐ Never ☐ Smokeless
If Current: How Many Years: _____ How Much Per Day: _____

Family History of Diabetes: ☐ No ☐ Yes: Whom _____

Medical History:	Yes	No		Yes	No		Yes	No
AIDs/HIV	Y	N	COVID Vaccine	Y	N	Psychiatric Care	Y	N
A-Fib	Y	N	Diabetic	Y	N			
Allergies to Anesthetics	Y	N	Dementia/Memory Loss	Y	N	Radiation Treatment	Y	N
Allergy: Medications	Y	N	Epilepsy	Y	N	Rash	Y	N
Anemia	Y	N	Eye Problems	Y	N	Respiratory Disease	Y	N
Angina	Y	N	Fainting	Y	N	Rheumatic Fever	Y	N
Alzheimer's	Y	N	Foot or Leg Cramps	Y	N			
Arthritis	Y	N	Gout	Y	N	Shortness of Breath	Y	N
Artficial Heart Valve	Y	N	Headache	Y	N	Sinus Problems	Y	N
Artificial Joint	Y	N	Hearing Loss	Y	N	MRSA	Y	N
Asthma	Y	N	Heart Disease	Y	N	Stroke	Y	N
Back Problems	Y	N	Hemophilia	Y	N	Swelling Ankles/Feet	Y	N
Bleeding Disorders	Y	N	Hepatitis	Y	N	Swollen Neck Glands	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Tired Feet	Y	N
Chemical Dependency	Y	N	Jaundice	Y	N	Tuberculosis	Y	N
Chest Pain	Y	N	Kidney Problems	Y	N	Ulcer Stomach	Y	N
Chronic Diarrhea	Y	N	Liver Disease	Y	N	Ulcer Foot	Y	N
Circulatory Problems	Y	N	Low Blood Pressure	Y	N	Varicose Veins	Y	N
COPD	Y	N	Nervous Problems	Y	N	Blood Clot-DVT	Y	N
COVID	Y	N	Phlebitis	Y	N	Wound	Y	N

List Other Diagnosis(s) Not Listed Above: _____

Surgeries You Have Had: _____

_____

_____

Hospitalization other than the surgeries listed: _____

_____

No Known Drug Allergies: ☐

Allergies: ☐ **Adhesive/Tape** ☐ **Anticoagulant Therapy** ☐ **Aspirin** ☐ **Codeine** ☐ **Demerol** ☐ **Iodine** ☐ **Local Anesthetics** ☐ **General Anesthetics** ☐ **Novocaine** ☐ **Penicillin** ☐ **Fish** ☐ **Shell Fish** ☐ **Sulfa**

Other: _____

Medications (Include prescriptions, over-the-counter and vitamins): _____

_____

_____

_____

Pharmacy Name: _____ **Location:** _____

Phone Number: _____ **Zip Code:** _____

Consent: I Certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Assignment and Release: I, the undersigned certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to Foot and Ankle Specialists for services rendered. I understand that I am Financially responsible for all charges whether or not paid by insurance. I here by authorize the doctor to release all information necessary to secure the payment of benefits. I authorized the use of the signature on all insurance submissions. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Responsible Party Signature: _____ Relationship_____ Date:_____

Foot and Ankle Specialists
Dr. Brian Przystawski
Dr. Dawn Michels
Dr. Brett Vessell

Acknowledgment of Receipt of and Consent to:
Notice of Privacy Practices and Cancellation and Telehealth Policy

HIPAA:
I acknowledge that I was provided a copy of the notice of Privacy Practices and that I have read it and was given opportunity to read and I understand this notice.

_____ Date:_____
Patient Name (Please Print)

_____ Date:_____
Parent or Authorized Representative (If Applicable)

_____ Date:_____
Signature

Please List other person(s) we can discuss your care with:

CANCELLATION:
I understand that Foot and Ankle Specialists has a 24 hour cancellations Policy and that If I do no show up for a scheduled appointment or call within 24 hour period I will be charged $25.00 fee.

_____ Date:_____
Signature

TELEHEALTH:
Telehealth involves the use of medial information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio/video telecommunication system that permits real-time communication to persons who are at some distance/restricted from the provider. The purpose is this telehealth service is to enable patients to receive medical care by a provider. I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identifications, imaging data and will include measures to safeguard the data, to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocol could fail, causing a breach in privacy of person medical information. Your provider may recommend a visit to an office or hospital for further evaluation. I understand that I have the right to withhold my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

Accept Telehealth: _____ Date:_____
Signature

Decline Telehealth: _____ Date:_____
Signature