# CENTER FOR FOOT AND ANKLE DISORDERS

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## NEW PATIENT REGISTRATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender/Pronouns _____

Marital Status _____ Social Security # _____

Home Telephone _____ Cell _____

Email _____

### Emergency Contact

Name _____

Telephone _____ Work # _____

Email _____

## EMPLOYER INFORMATION

Employer _____

Address _____ Tel # _____

City _____ State _____ Zip _____

## INSURANCE INFORMATION

Primary Insurance Company _____

City _____ State _____ Zip _____

Guarantor Name _____

Date of Birth _____ Social Security # _____

Secondary Insurance Company _____

Address _____

City _____ State _____ Zip _____ Tel # _____

## PRIMARY CARE PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

## REFERRAL

Who can we thank for referring you to this office?

Name _____

Telephone _____

## PHARMACY

Which pharmacy do you prefer us to escribe, call in, or send/mail your prescriptions to?

Name _____

Address _____

City _____ State _____ Zip _____

## REASON FOR TODAY'S VISIT

What is the problem that brought you in to see us today?

_____

_____

**Please circle a number on the pain scale below if you are experiencing any pain at this time that pertains to your chief complaint.**


## MEDICAL HISTORY

Please check any of the following that pertain to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Poor Circulation
- ☐ Diabetes
- ☐ Difficulty Healing
- ☐ Frequent Infections
- ☐ Blood Pressure
- ☐ Heart
- ☐ HIV / AIDS
- ☐ Kidney Problems
- ☐ Leg Cramps
- ☐ Lung Disorders
- ☐ Epilepsy
- ☐ Phlebitis
- ☐ Edema
- ☐ Gout
- ☐ Other

**Please list all medications you are taking now**

1. _____

2. _____

3. _____

## MEDICAL HISTORY (CONTINUED)

Have you been under the care of a doctor for the past two years? ☐ Yes ☐ No

If yes, what for _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list _____

**Please list any surgeries you have had in the past**

_____

_____

**Any medical history you feel the doctor needs to know**

_____

_____

All information I have provided is correct and accurate.

Patient Signature _____ Date _____

## EMAIL PRIVACY ACKNOWLEDGEMENT

> If you choose to email a doctor or employee of the practice, please be advised that we use commercial email addresses and your privacy is subject to the commercial email company's security. We cannot guarantee your medical privacy as we do not control that security.

Patient Signature _____ Date _____

## RECORDING POLICY

> Please be advised that we do not allow any video or audio recording of treatment visits or testing, as this is a violation of our office policy and HIPAA.

Patient Signature _____ Date _____

## ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I request payment of authorized Medicare and/or other insurance benefits be made on my behalf to Dr. H.D. Schoenhaus, P.C. for any services furnished to me by physicians that are part of this practice.

I authorize any holder of medical information about me to be released to the health care financing administration and/or other insurance carriers and their agents of any information necessary to determine benefits and/or the benefits payable for related services.

I understand that I am responsible for any and all non-covered services, deductibles, and/or co-insurance not covered by my insurance carrier. I personally guarantee payment for such services and, in the event I fail to remit timely payment, authorize my attorney (if applicable) to deduct the payment from any proceeds, by settlement, judgment or otherwise, recovered on my behalf in connection with the events giving rise to the physician services I have received.

Patient Signature _____ Date _____

Attorney Signature _____ Date _____

Office Representative _____ Date _____

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

Written Acknowledgement Form • Dr. H.D. Schoenhaus, P.C.

I, _____ , have received a copy of the notice of privacy practices.

Patient Signature _____ Date _____

Patient Representative _____ Date _____

Office Representative _____ Date _____