Iberia Foot Specialists, LLC

Patient Registration Form

Thank you for choosing our office! In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Date_____ Patient Name_____
Last First MI

SSN_____ ☐ Male ☐ Female Age_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Email 1_____ Email 2_____

Check appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Domestic Partner

Race: ☐ American-Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Language: ☐ English ☐ French ☐ German ☐ Japanese ☐ Spanish ☐ Mandarin ☐ Russian

Dominant Hand: ☐ Left ☐ Right ☐ Ambidextrous

Employer_____ Occupation_____ Work Phone_____

Driver's License #_____ Spouse's Name_____

Emergency Contact Name _____ Phone _____

Emergency contact relationship to patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other Adult ☐ Other Relation

Is this person authorized to make medical decisions? ☐ Yes ☐ No

Whom may we thank for referring you? _____

RESPONSIBLE PARTY (Complete Only if Different From Above)

Name of person responsible for this account_____ Relationship to patient _____

SSN_____ ☐ Male ☐ Female Age_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Work Phone_____

Driver's License #_____ Spouse's Name_____

Primary Insurance Company_____

Subscriber Name_____

Subscriber Birthdate _____

Relationship to Patient_____

Policy #:_____

Group #: _____

Secondary Insurance Company_____

Subscriber Name_____

Subscriber Birthdate _____

Relationship to Patient_____

Policy #:_____

Group #: _____

OFFICE POLICY REGARDING INSURANCE

To preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1) Professional services are rendered and charged to the patient and not to the insurance company. You, the patient, are directly responsible for payments to the doctor. A health insurance policy is a contract between you (as subscriber) and your insurance company.

2) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard, or Visa

3) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you (the patient or guardian) are responsible for all charges incurred.

4) If any types of supplies are dispensed during the course of treatment, (e.g. arch supports, accommodative pads, creams, surgical shoes, etc) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

5) I have read, understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

6) 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 chose) and understood the Notice.

_____ _____

Signature (Parent, if patient is a minor) Date

I hereby give permission to Dr. Green/Iberia Foot Specialists, LLC to evaluate, treat and perform procedures deemed necessary in the treatment of my foot condition. I authorize disclosure of medical information, including but not limited to, electronic access of any medication history, assistance in insurance claim process and communication with treating physicians. Furthermore, I assign all payment of medical benefits provided by my insurance policy for medical/surgical care to Dr. Green/Iberia Foot Specialists, LLC.

_____ _____

Signature (Parent, if patient is a minor) Date

Medical Information

Primary Care Doctor: _____ Last Visit: _____

Previous Podiatrist: _____ Last Visit: _____

Chief Foot Complaint: _____

How long has it been present? _____Weeks _____Months _____Years

Previous foot/ankle surgeries: _____

Previous surgeries (other than foot/ankle): _____

_____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Height:_____ Weight:_____ Shoe Size:_____

NAME OF MEDICATION	**MG/STRENGTH**	**Frequency (times per day)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History: □ Diabetes □ Arthritis □ Heart Disease □ Cancer

□ Poor Circulation □ Stroke □ High Blood Pressure □ Kidney Disease

Are you allergic to any of the following? □ Latex □ Penicillin □ Sulfa □ Codeine

□ Adhesive Tape □ Iodine □ Other: _____

Do you smoke? □ No □ Yes _____ Packs per day

Do you use smokeless tobacco? □ No □ Yes

Do you drink? □ No □ Yes _____ Drinks per day

(Women) Are you pregnant? □ No □ Yes

Medical Information

Have you ever had, or been treated for, any of the following?

MAJOR DISEASE

□ Diabetes

□ High Blood Pressure

□ Angina

□ Heart Disease

□ Heart Attack

□ Arrhythmia

□ Heart Murmur

□ Mitral Valve Prolapse

□ Stroke

□ High Cholesterol

ARTHRITIS

□ Osteoarthritis

□ Rheumatoid

□ Gout

□ Fibromyalgia

PSYCHOSOCIAL

□ Anxiety

□ Depression

□ Psychiatric Care

□ Drug Dependence

□ Alcohol Dependence

□ Bipolar Disorder

HEENT

□ Headaches

□ Glaucoma

□ Hearing Problems

VASCULAR

□ Anemia

□ Prolonged Bleeding

□ Pacemaker

□ Poor Circulation

□ Leg Pain When Walking

□ Blood Clots

□ Varicose Veins

MISCELANEOUS

□ Epilepsy/Seizures

□ Thyroid Disease

□ Muscle Disease/Polio

□ Kidney Problems

□ Dialysis

□ Bladder Problems

□ Prostate Problems

□ HIV

□ Hepatitis/Liver Disease

□ Cancer (Type :_____)

RESPIRATORY

□ Asthma

□ Tuberculosis

□ Emphysema

□ Shortness of Breath

GASTROINTESTINAL

□ Ulcers

□ Acid Reflux (GERD)

□ Stomach Problems

□ Hiatal Hernia

□ GI or Rectal Bleeding

□ Bowel Disorders

OTHER MEDICAL PROBLEMS

_____

_____

_____