The Foot Institute

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LOCATION:
[ ] 114 W. Castellano Dr
[ ] 8815 Dyer St., Suite 348

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____

Address: _____
City, State, Zip Code: _____

Primary Phone Number: [ ] Cell [ ] Home [ ] Office/Work _____
Secondary Phone Number: [ ] Cell [ ] Home [ ] Office/Work _____

Emergency Contact Name: _____
Emergency Contact Phone Number: _____
Relationship to Patient: [ ] Spouse [ ] Significant Other [ ] Friend [ ] Other: _____

Referral Source: _____ (bill board, website, doctor office, etc.)

Primary Care Provider (PCP): _____
PCP Phone Number: _____ Date PCP Last Seen: _____

Primary Insurance: _____ **Member ID No.:** _____
Secondary Insurance: _____ **Member ID No.:** _____

CONSENT TO TREAT: I request and give consent to The Foot Institute and Physician to evaluate, provide treatment(s) and to perform such medical/surgical care, tests, procedures, medications and all other services deemed necessary or beneficial by physicians and clinical staff. I acknowledge that no representations, warranties or guarantees as to the results or cure have been made to me or relied upon by me.

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR CLAIMS: I authorize the The Foot Institute and Physician(s) to release information from my medical records to my insurance carrier(s), governmental agencies, and/or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and sate on such claims that my signature is on file. I request that all entities honor my assignment of insurance benefits and authorize payment of such benefits be paid directly to my physician on my behalf
.

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient, and/or patient's responsible party guarantor. As a courtesy, The foot Institute verifies Insurance benefits prior to the patient's appointment and may not guarantee payment for the medical services provided. I understand it is the patient's responsibility to make sure all payments are processed and paid promptly to my physician. I agree and promise to pay any and all unpaid balances, including but not limited to legal interest on any balance(s) due, collection fees/costs and reasonable attorney fees incurred to effect collection of this account or future accounts.

SCHEDULED APPOINTMENTS/NO SHOW FEES: Scheduled patient appointments are valuable to us here at The Foot Institute and as a specialist office, scheduling times are very limited and are therefore, honored. We ask that you provide a 24 hour notice to cancel or reschedule your appointment. If you are unable to keep your scheduled appointment, a $25 No Show fee will be assessed.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have read the laminated Notice of Privacy Practices and understand that my Protected Health Information may be used by the Practice as described in the notice andI may request a copy of the notice at the time of my visit.

Patient/Guardian: _____ Date: _____
Signature

Witness: _____ Date: _____
TFI Representative

The Foot Institute

PATIENT INTAKE FORM

Vitals: Temp: _____
BP: _____/_____
Weight: _____
Height: _____

Date: _____

Patient Name: _____ **DOB:** _____

Reason for Visit/Complaint: _____

Referred by PCP (Name/Specialty)? _____ Other: _____

Are you experiencing any pain? [ ] Yes [ ] No

Pain Level: [ ] Mild [ ] Moderate [ ] Severe

Type of pain/issues: [ ] Dull [ ] Sharp [ ] Tingling [ ] Numbness [ ] Other

Duration of pain/issues: [ ] 0 – 3 months [ ] 3 – 6 months [ ] 6 – 12 months [ ] 3+ year(s)

Medical History:

Females Only: Are you pregnant? [ ] Yes [ ] No Date of LMP? _____
If yes, how far long? _____

Allergies to medications? [ ] No [ ] Yes If yes, please list _____

_____

Do you use tobacco? [ ] Yes [ ] No
If yes, how much? _____

Do you drink alcohol? [ ] Yes [ ] No
If yes, how much? _____

Past Medical History: Have you ever had or been diagnosed with the following:

Diabetes:	[ ] Yes	[ ] No	High Blood Pressure:	[ ] Yes	[ ] No
Arthritis:	[ ] Yes	[ ] No	Heart Problems:	[ ] Yes	[ ] No
Recent Weight Loss	[ ] Yes	[ ] No	Stomach Ulcers:	[ ] Yes	[ ] No
Blood Clots:	[ ] Yes	[ ] No	Kidney/Liver Issues:	[ ] Yes	[ ] No
Scarring Tendencies:	[ ] Yes	[ ] No	Bleeding Tendencies:	[ ] Yes	[ ] No
Joint Replacement	[ ] Yes	[ ] No	Hepatitis,HIV, or AIDS	[ ] Yes	[ ] No

Past Surgical History: Please list all surgeries with dates you have had: _____

_____

Family History: Has any member of your immediate family ever had or been diagnosed with the following:

Diabetes:	[ ] Yes	[ ] No	High Blood Pressure:	[ ] Yes	[ ] No
Arthritis:	[ ] Yes	[ ] No	Heart Problems:	[ ] Yes	[ ] No
Kidney/Liver Issues:	[ ] Yes	[ ] No	Stomach Ulcers:	[ ] Yes	[ ] No
Blood Clots:	[ ] Yes	[ ] No	Hepatitis,HIV, or AIDS	[ ] Yes	[ ] No
Bleeding Tendencies:	[ ] Yes	[ ] No	Cancer-Type?	[ ] Yes	[ ] No

Other Medical Problems you have not listed above: _____

_____

I certify that the above information is true and correct to the best of my knowledge.

_____ Date: _____
Patient Signature (or legal guardian if patient is a minor)

Information taken by: _____ Date: _____
TFI Representative

The Foot Institute

MEDICATION LIST/*LISTA DE MEDICAMENTOS*

Patient Name: _____ **DOB:** _____
Nombre de Paciente ***Fecha de Nacimiento***

Are you taking any blood thinners? [ ] Yes / *Si* **[ ] No**
Estás tomando anticoagulantes?

Date/ *Fecha*	**Medication Name/Strength** *Nombre del medicamento / Fuerza*	**Generic Allowed?** *Genérico permitido?*