Physician and Surgeon of the Foot and Ankle

Advanced Footcare Group, P.C.
REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP___________________________

PATIENT INFORMATION

Patient's Last Name	**First**	**Middle**	
❑ Mr. ❑ Miss ❑Mrs. ❑ Ms	Marital Status (**Circle One**) Single / Mar / Div / Sep / Wid	Birth Date / /	Sex ❑ M ❑ F

Address	Social Security #	Home Phone No. ( )
City State ZIP Code	Email:	

Occupation	Employer	Business Phone No. ( )	Cell Phone No. ( )

Referred to Advanced Footcare Group, P.C. by: ❑Friend/Co-worker ❑Doctor Referral ❑Newspaper ❑Insurance Co.

❑ Relative ❑Internet ❑Yellow Pages ❑Google ❑Yelp ❑Angie's List ❑ Linkedin ❑Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

NAME OF PRIMARY INSURANCE:

Policyholder's name.	Policyholder's S.S. #	Birth Date / /	Group #	Policy #	Co-payment $

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑Other

NAME OF SECONDARY INSURANCE	Policyholder's Name	Group #	Policy #

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑Other

Pharmacy Name	**Pharmacy Address**	**Pharmacy Phone Number**

Medical Doctor's Name/Address

Current foot complaint/symptoms

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Footcare Group or insurance company to release any information required to process my claims. I acknowledge that I was provided and read (or had the opportunity to read)and understood ***The Notice of Privacy Practice* I am aware that the following information is available for viewing upon request;**

Information regarding the providers of care in this organization
A copy of the Patient's Bill of Rights and Responsibilities
Information regarding the grievance process

Ownership of Practice
DNR Policy
JCAHO Information

please sign below

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO ADVANCED FOOTCARE GROUP, P.C. x ________________________________

DATE___________________________

HIPPA AUTHORIZATION x ________________________________

PATIENT/GUARDIAN SIGNATURE x________________________________

MEDICAL HISTORY

Patient Name	Birth date / /

Allergies: List Known allergies or reactions to Drugs / Medications

❑ Penicillin or other antibiotic	❑ Sulfa	❑ Local Anesthetic	❑ Codeine/Percocet	❑ Anti-inflammatory Medication
❑ Nausea From Anesthetic	❑ Aspirin	❑ Adhesive Tape	❑ Iodine on Skin	❑ Cortisone
❑ Demerol	❑ Latex	❑ Ibuprofen	❑ Novocaine	❑ Other

Medications: Please list current medications that you are taking:Prescription or over the counter

Medication	Dose	Reason taking	Medication	Dose	Reason taking
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Foot/Ankle Pain How Long?	Months	Years	Where?

Recently ill? Explain: Surgery? Explain:

What Previous Treatment Have you had on your Foot/Ankle?:

❑ Surgery	❑ Orthotics	❑ Oral Medications	❑ Cortisone Shots

Family Physician Information

Medical Doctor's Name	Phone Number ( ) -		
Street Address	City	State	Zip

Have you ever been put to sleep for surgery? ❑ yes ❑ no

Shoe Size	Height	Weight

Do you drink?	❑ yes ❑ no	Drinks per week
Do you smoke?	❑ yes ❑ no	How long? Pack(s) per day

Indicate which of the following you have had or have at present. Please check yes or no to each item

AIDS/HIV	❑ yes	❑ no	DIZZINESS/FAINTING	❑ yes	❑ no	MENOPAUSE	❑ yes	❑ no
ALCOHOLISM	❑ yes	❑ no	EMPHYSEMA	❑ yes	❑ no	NEUROLOGICAL DISORDER	❑ yes	❑ no
ANEMIA	❑ yes	❑ no	EPILEPSY/SEIZURES	❑ yes	❑ no	NEUROPATHY	❑ yes	❑ no
ARTHRITIS (RHEUMATOID)	❑ yes	❑ no	FIBROMYALGIA	❑ yes	❑ no	OBESITY	❑ yes	❑ no
ARTIFICIAL JOINTS	❑ yes	❑ no	Gastrointestinal PROBLEMS (REFLUX, HEARTBURN, ULCERS))	❑ yes	❑ no	OSTEOMYELITIS	❑ yes	❑ no
ASTHMA	❑ yes	❑ no	GLAUCOMA	❑ yes	❑ no	PHLEBITIS	❑ yes	❑ no
BLEEDING DISORDER (HEMOPHILIA)	❑ yes	❑ no	GOUT	❑ yes	❑ no	PSYCHIATRIC or PSYCHOLOGICAL CARE	❑ yes	❑ no
BLOOD CLOTS (DVT/PE)	❑ yes	❑ no	HEART DISEASE	❑ yes	❑ no	RAYNAUD'S	❑ yes	❑ no
BLOOD THINNER	❑ yes	❑ no	HEART MURMUR	❑ yes	❑ no	SICKLE CELL	❑ yes	❑ no
CANCER	❑ yes	❑ no	HEPATITIS	❑ yes	❑ no	SKIN CANCER	❑ yes	❑ no
CHEMICAL DEPENDENCY	❑ yes	❑ no	HIGH BLOOD PRESSURE	❑ yes	❑ no	THYROID DISEASE	❑ yes	❑ no
DEPRESSION	❑ yes	❑ no	INFECTION PRONE	❑ yes	❑ no	TUBERCULOSIS	❑ yes	❑ no
DIABETES	❑ yes	❑ no	KIDNEY DISEASE	❑ yes	❑ no	VASCULAR DISEASE	❑ yes	❑ no
DIALYSIS	❑ yes	❑ no	LIVER DISEASE	❑ yes	❑ no	VENEREAL DISEASE	❑ yes	❑ no

I understand the above medical information is necessary to provide me with medical care in a safe and efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the doctor of any changes in my health condition or medication.

X	/ /
Patient/Guardian Signature	**Date**

History Reviewed by : Dr Signature : Date: / /

PATIENT'S NAME ____ DOB _____________________

INSURANCE CHECKS SENT TO THE PATIENT

I have been informed by Advanced Footcare Group that the checks from my Insurance company may be sent directly to me.

These insurance carriers will send checks to the patient:

1. **Blue Cross/Blue Shield**
2. **Oxford Health Plans**
3. **Empire Plan (Government Workers)**
4. **GHI**
5. **United Health Care**
6. **Cigna**

I AGREE TO GIVE THESE INSURANCE CHECKS TO ADVANCED FOOTCARE GROUP, P.C.

I understand that these checks from my insurance company are for services provided to me by either:

- **Advanced Footcare Group, P.C.**
- **Anesthesiologist: Mark Pollner**
- **Doctors:**

*** Dr. Howard Zaiff - Dr. Louis Belcastro**

***Being a GROUP Practice, the statement from the Insurance Carrier may have the name of a different doctor other than your main doctor.**

I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESE CHECKS.

******** IN THE EVENT I FALSELY WITHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATLY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO ADVANCED FOOTCARE GROUP OR ANY OF THE DOCTORS MENTIONED ABOVE.**

If I get insurance checks, for services provided by Advanced Footcare Group, or any of the podiatrist or Anesthesiologist, I agree to forward them directly to Advanced Footcare Group.

________________________	____________________	_____________
Print Name	Sign Name	Date