PALM BEACH FAMILY FOOT CARE
O N E S T E P A T A T I M E

PODIATRIC PATIENT REGISTRATION & HISTORY

1. PATIENT INFORMATION

Date: ____________________________

Name: ____ **Sex:** □ M □ F **Age:** _______

Birthdate: _________________________ **Social Security Number:** ______ - ______ - ______

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Email Address: ____________________________________@____

Home Address
_______________________________________ **City** ______________ **State** _______ **Zip Code** ________

Alternate Northern Address (If applicable)
_______________________________________ **City** ______________ **State** _______ **Zip Code** ________

Home Phone: __________________ **Work Phone:** ___________________ **Cell Phone:** ________________

Occupation: __________________________________ **Employer:** ______________________________________

Employer Address: _________________________ **Employer Phone #:** _______________________________

Primary Care Physician Name: ____

Physician Phone #: _________________________ **Date Last Seen By Physician:** _____________________

IN CASE OF EMERGENCY, CONTACT:
Name: ____________________ **Relationship:** ______________ **Telephone #:** _________________________

Whom may we thank for referring you to us?
□ **Website** □ **Yellow Book** □ **Community Paper** □ **Friend** □ **Other** _______________

Dr. Brian S. Frenchman | *Medicine & Surgery of the Foot*
15300 Jog Road Suite # 110, Delray Beach, Florida 33446
Telephone (561) 498-9066 | Facsimile (561) 498-9068 | DelrayFootDoctors.com

2. INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Company ______________________________
Insurance ID Number ______________________________
Insurance Group Number ______________________________

SECONDARY INSURANCE
Insurance Company ______________________________
Insurance ID Number ______________________________
Insurance Group Number ______________________________

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH THE ABOVE STATED INSURANCE COMPANY(IES) AND ASSIGN DIRECTLY TO DR. FRENCHMAN ALL INSURANCE BENEFITS. MEDICARE AND OTHER, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAYABLE BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ALL INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. BY SIGNING BELOW, YOU ALSO GIVE PERMISSION FOR OUR OFFICE TO ACCESS YOUR PHARMACY DATA ELECTRONICALLY THROUGH SURE SCRIPTS, WHICH WILL ENABLE OUR OFFICE TO DOWNLOAD A HISTORIC LIST OF ALL MEDICATIONS PRESCRIBED BY OTHER PROVIDERS. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

______________________ ______________________ ______________________
RESPONSIBLE PARTY SIGNATURE **RELATIONSHIP** **DATE**

3. MEDICAL HISTORY DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

□ ASTHMA □ AIDS/ HEPATITIS □ ARTHRITIS □ ANEMIA □ DIABETES (INSULIN DEPENDENT)

□ DIABETES (NON-INSULIN DEPENDENT) □ EPILEPSY □ GOUT □ HEART DISEASE

□ HYPOTHYROIDISM □ HYPERCHOLESTEROLEMIA □ HIGH BLOOD PRESSURE

□ KIDNEY DISEASE □ LIVER DISEASE □ POOR CIRCULATION □ CANCER

IS THERE A FAMILY HISTORY OF DIABETES? □ YES □ NO

HAVE YOU EVER HAD ANY SURGERY? □ YES □ NO
IF YES WHAT? ______________________ **WHEN?** ______________________

DO YOU SMOKE? □ YES □ NO **DO YOU DRINK?** □ YES □ NO

4. MEDICATIONS (PLEASE LIST ALL IN THE SPACES PROVIDED BELOW)

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

5. ALLERGIES (CIRCLE ALL THAT APPLY)

◻ ADHESIVE TAPE ◻ COAGULANT THERAPY ◻ ASPIRIN ◻ CODEINE ◻ DEMEROL ◻ IODINE

◻ LOCAL ANESTHETICS ◻ PENICILLIN ◻ SEAFOODS ◻ SULFA ◻ OTHER ________________________

PLEASE EXPLAIN YOUR ALLERGIC REACTION: ____

____

6. PODIATRIC HISTORY

HAVE YOU EVER BEEN TREATED BY A PODIATRIST BEFORE? ◻ **YES** ◻ **NO**

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED?

____

HOW LONG HAVE YOU HAD THIS COMPLAINT FOR? ◻ ____ DAYS ◻ ____ WEEKS ◻ ____ MONTHS

DOES ANYTHING RELIEVE THE SYMPTOMS? ____

____

7. CONSENT

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/ OR TREATMENT OF MY FEET.

________________________________ ________________________

PATIENT'S SIGNATURE **DATE**

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PATIENT AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________ , hereby authorize Palm Beach Family Foot Care, P.A. (the "Practice") to use and/or disclose specific protected health information:

I understand that this authorization is valid until otherwise rescinded in writing. I understand that the purpose or use of the disclosure I am granting is to obtain insurance or necessary medical information.

I expressly acknowledge that this authorization is voluntary. I understand that the office will not receive financial or in–kind compensation in exchange for using or disclosing the health information described above.

I understand that the information may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.

I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and its contents. I also acknowledge that I was provided a copy of the Notice of Privacy Practices upon my request and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

This authorization is valid as of ______ / ______ / _________, the date I have signed below.

________________________________	________________________________
Name of Individual (Printed)	Signature of Individual
________________________________	________________________________
Signature of Legal Representative	Relationship

Witness: (e.g. Attorney-In-Fact, Guardian, Parent if a Minor)