



# FOOT AND ANKLE CLINIC OF MIDFLORIDA

## Patient Registration Information (Please print all information)

Who is responsible for patient: Self Parent Other \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle

Mother's Name if Minor Patient: \_\_\_\_\_ Father's Name if Minor Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt# City State Zip

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex:  M  F Marital Status:  Single  Married  Divorced  Widowed  Separated Preferred Language: \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell phone# \_\_\_\_\_ Email Address \_\_\_\_\_

Ethnicity(Circle): Hispanic Non Hispanic Race (circle): Black White Asian Hispanic Other \_\_\_\_\_

Employment Status:  Full-Time  Part Time  Retired  Unemployed  Other \_\_\_\_\_  Student:  Full-Time  Part Time

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone#: \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone# \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### Responsible Party Information(if other than parent/spouse)

Head of Household/ Guardian/ Custody of Minor \_\_\_\_\_ Relationship to parent \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone # \_\_\_\_\_

### Insurance Information

Policy Holder (Spouse or Responsible Party If Not Self)

Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

#### Primary Insurance

EFFECTIVE DATE: \_\_\_\_\_

Insurance Carrier \_\_\_\_\_  
Name Address Phone Number

Policy#: \_\_\_\_\_ Group No.: \_\_\_\_\_

#### Secondary Insurance

EFFECTIVE DATE: \_\_\_\_\_

Insurance Carrier \_\_\_\_\_  
Name Address Phone Number

Policy Number \_\_\_\_\_ Group No.: \_\_\_\_\_

I hereby give lifetime authorization to the Foot and Ankle Clinic of MidFlorida to perform treatment, medical and surgical procedures including administration of medicine that may be medically necessary. I authorize the release of my signature on any insurance submission, the release of any medical information necessary and give authorization for payment of insurance benefits to be made directly to Foot and Ankle Clinic of MidFlorida and any assisting physicians for services rendered by the Foot and Ankle Clinic of MidFlorida. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be valid as the original.

\_\_\_\_\_  
Patient / Legal Guardian / Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Patient / Legal Guardian / Legal Representative (PRINT NAME)



**HISTORY AND PHYSICAL FORM (Please fill out form entirely)**

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Foot / Ankle Complaint: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Name Telephone Address

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**Past Medical History (Check all that apply)**

- Diabetes      Hypertension    Nervous Conditions    Stroke    Arthritis    Sickle Cell Anemia
- Skin Problems    Leg Cramps    Bleeding Disorder    Heart Disease    Kidney Problems
- Fainting Spells    Gout      Varicose Veins    Neurological Disorders    High Cholesterol    Seizure Disorder
- Bruise Easily    Cancer      Nervousness    AIDS    Other/ Explain: \_\_\_\_\_

**Past Surgical History:**

<u>Hospitalizations/Surgeries</u>	<u>Date</u>	<u>Hospitalizations/Surgeries</u>	<u>Date</u>

**Allergies :**

Explain: \_\_\_\_\_

**Medications:** *If more space is required for medications, please continue on the back of this page.* [  Tick if back of the page is used.]

Name:	Dosage	Directions	Name:	Dosage:	Directions:

**Family History: Check M for Mother; F for Father; S for Sister; and B for Brother; to all that apply**

\_\_\_\_\_ Diabetes    \_\_\_\_\_ Hypertension    \_\_\_\_\_ Bleeding Disorders    \_\_\_\_\_ Heart Disease    \_\_\_\_\_ Strokes

\_\_\_\_\_ Kidney Disease    \_\_\_\_\_ Cancer    \_\_\_\_\_ Arthritis, Gout    \_\_\_\_\_ Tuberculosis    \_\_\_\_\_ Other

**Mother-:** Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_      **Father-:** Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_

**Sister-:** Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_      **Brother-:** Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_

\_\_\_\_\_-: Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_      \_\_\_\_\_-: Age:\_\_\_\_State of Health:\_\_\_\_\_ Age of Death\_\_\_\_\_

**Social History: Check all that apply**

- Tobacco (pkg/day)      Coffee (cups/day)      Alcohol (How often?)      Substance Abuse (Explain)

**By signing this, I agree that all information is correct and up to date. I understand that reporting incomplete and inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions and it is my responsibility to inform my Doctor if I ever have a change in health.**

\_\_\_\_\_  
**Patient / Legal Guardian / Legal Representative Signature**



Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS**

I hereby authorize the Foot and Ankle Clinic of MidFlorida to discuss and release my protected health information with: (If you would like to add additional family members, please use the back of this form, which must also be signed and dated.)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Unless specified, this authorization will not expire. I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal law.

Signature: Patient / Legal Guardian / Legal Representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS**

**Required Co-Payments / Co-Insurance / Deductibles:** This is an insurance requirement. Any co-payments / co-insurance / deductibles required and outlined by the insurance company must be paid by me at the time of service.

**Account Balance / Statement of Account:** If I have a balance on my account, I am required to pay immediately. I may receive a statement showing the balance on the account and any payments or credits applied during the period.

**Payments:** Unless other arrangements are approved by the Foot and Ankle Clinic of MidFlorida in writing, the balance on my account / statement is due and payable immediately. Payments may be made by check, credit card or cash at the office on any day the office is opened or on the day service is rendered.

By signing immediately below, I agree to the financial policy outlined.

Signature: Patient / Legal Guardian / Legal Representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF HEALTH INFORMATION PRACTICES FOR THE FOOT AND ANKLE CLINIC OF MIDFLORIDA AND E-PRESCRIBING CONSENT**

By signing immediately below, I hereby expressly acknowledge receipt of my copy of the Notice of Information Practices for the Foot and Ankle Clinic of MidFlorida.

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Foot and Ankle Clinic of MidFlorida uses E-Prescribing as the primary form of transmitting prescriptions. Consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and / or third party benefit payors (i.e. your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to the Foot and Ankle Clinic of MidFlorida to E-Prescribe.

Signature: Patient / Legal Guardian / Legal Representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_