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)

FOOT AND ANKLE CLINIC OF MIDFLORIDA

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:

Hospitalizations/Surgeries	**Date**	**Hospitalizations/Surgeries**	**Date**

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

FOOT AND ANKLE CLINIC OF MIDFLORIDA

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
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