

New Patient Registration Form

Dr. Gianni Persich

1. PATIENT INFORMATION

Date _____
Patient _____
Address _____

City State Zip
Sex: M F Age ____ Birthdate _____
 Single Married Widowed Separated Divorced
Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Spouse's Name _____
Birthdate _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a Podiatrist before?
 Yes No

If yes, please list.

Name _____
Last visit _____

Is there any personal or family history of diabetes? Yes No

Your occupation _____
Cigarette/Tobacco use _____
Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain Yes No
Athlete's Foot Yes No
Bunions Yes No
Corns and Calluses Yes No
Cramps or Numbness in Feet or Legs Yes No
Flat Feet Yes No
Foot or Leg Cramps Yes No
Heel Pain Yes No
Ingrown Toenails Yes No
Plantar Warts Yes No
Swelling in Ankles or Feet Yes No
Tired Feet Yes No

2. INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber Name _____
Birthdate _____ SS # _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Gianni Persich, All County Foot & Ankle, LLP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Persich/Gaudino _____ for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Relationship

Date

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

6. MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

7. ALLERGIES

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sea foods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

CONSENT

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