PODIATRIC REGISTRATION FORM

NAME _____ **SEX** _____ **BIRTHDATE** _____

ADDRESS _____

city **state** **zip**

HOME PHONE # _____ **WORK PHONE** _____

E-MAIL _____ **CEL PHONE** _____

OCCUPATION _____ **EMPLOYER** _____

IN CASE OF EMERGENCY, CALL

_____

NAME **RELATIONSHIP** **PHONE #**

PLEASE READ AND SIGN BELOW

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Michael Rosenblum all insurance benefits, if any, otherwise payable to me for services rendered. I authorize payment of medical benefits to Dr. Michael Rosenblum. 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.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Michael Rosenblum for any services furnished 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 that my signature requests that payment be made and authorize 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 release of 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 for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

HIPPA Privacy Practices Notice: I acknowledge that I have read/received a notice of privacy practices. ×_____initial

Medication History: I authorize the Doctor's office to retrieve my medication history. ×_____initial

Financial Policy: I acknowledge that I have read, agreed to and received a copy of the financial policy. ×_____initial

Appointment Cancellation Policy: I acknowledge that I have read, agreed to and received a copy of the cancelation policy. ×_____initial

The information on my intake form is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed.

I hereby give my permission to the doctor to administer and perform testing/procedures as deemed necessary for the diagnosis and treatment of my problem(s).

_____ _____

Beneficiary/Responsible Party Signature Date

MEDICAL HISTORY

Please indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artificial Valves
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Carpal Tunnel Synd.
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Eye Problems
- ☐ Dizziness/ Fainting
- ☐ Gastritis
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Nausea/Vomiting
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss

Any other pertinent info?

_____

_____

☐ **I have no medical problems**

MEDICATIONS:

name_____ name_____

name_____ name_____

name_____ name_____

name_____ name_____

☐ **I do not take any medications**

Primary Care Physician_____ **Approx Date Last Seen**_____

If you are Diabetic,
Physician treating your Diabetes_____**Approx Date Last Seen**_____

SURGICAL HISTORY: ☐ I have not had any surgeries

name_____ approximate date_____

name_____ approximate date_____

name_____ approximate date_____

ALLERGIES: ☐ I have no know allergies

name_____reaction_____

name_____reaction_____

name_____reaction_____

name_____reaction_____

SOCIAL HISTORY:

Smoking Status: ☐Current Every Day ☐Current, Some Days ☐Former Smoker ☐Never

Substance/Alcohol Abuse? ☐NO ☐YES (specify)_____

VITALS: Height_____ Weight_____ Blood Pressure_____/_____

What is your **shoe size**? _____ **Width**: ☐Narrow ☐Regular ☐Wide ☐XW

Family History:

Mother:	☐Diabetes	☐Arthritis	☐Heart Disease	☐Cancer	☐Other_____
Father:	☐Diabetes	☐Arthritis	☐Heart Disease	☐Cancer	☐Other_____
Sister:	☐Diabetes	☐Arthritis	☐Heart Disease	☐Cancer	☐Other_____
Brother:	☐Diabetes	☐Arthritis	☐Heart Disease	☐Cancer	☐Other_____

REVIEW OF SYSTEMS: (Please check the appropriate boxes or check "NONE")

Musculoskeletal: ☐back pain ☐sciatica ☐arthritis ☐muscle weakness ☐joint instability ☐muscle aches ☐gout ☐NONE

Gastrointestinal: ☐abdominal pain ☐ulcers ☐constipation ☐diarrhea ☐nausea ☐vomiting ☐GERD ☐Crohns ☐NONE

Neurological: ☐tingling ☐numbness ☐tremors ☐seizures ☐headaches ☐weakness ☐paralysis ☐double vision ☐NONE

Integumentary: ☐rash ☐psoriasis ☐nail abnormality ☐skin ulcers ☐skin cancer ☐dry, scaly skin ☐varicose veins ☐NONE

Cardiovascular: ☐cold hands/feet ☐Chest Pain ☐Heart Attack ☐leg pain when walking ☐leg swelling ☐fainting ☐NONE

Constitutional: ☐fever/chills ☐night sweats ☐fatigue ☐malaise ☐unexplained weight gain/loss ☐loss of apetite ☐NONE

MIPS 117 Dr. Michael Rosenblum Patient:_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

Race: □ White □ Black or African American □Asian □American Indian □ Pacific Islander □Decline to Specify

Preferred Language:_____

PODIATRIC HISTORY: Is this visit a result of an accident or work injury? □Yes □No

What is the reason for your visit today?_____

How long has this bothered you? □ Days □ Weeks □ Months □ Years

Rate your pain scale 1- 10 (1 being no pain and 10 being the worst) ___/10

Pharmacy Name _____ Street, City, State_____

Privacy Information Preferences:

Do you want to be exempt from public reporting? □ Yes □No

Can we call the phone number on file? □ Yes □No

Can we send mail to the address on file? □ Yes □No

Can we leave voicemail? □ Yes □No

Can we send internet based delivery of reminders, etc.? □ Yes □No

Who can we leave messages with? Name:_____Relation:_____

Did you receive a **FLU shot** this season? □ Yes □No Did you get a **Pneumonia vaccination**? □ Yes □No

Have you **fallen** in the last 12 months? □ Yes □No Were you **injured** from the fall? □ Yes □No

Have you completed any Advanced Directives? □ Yes □No

An Advance Directive is a document that allows you to direct who will make healthcare decisions for you and to state your wish for medical treatment if you become unable to decide for yourself in the future.

□ I have a Do Not Resuscitate Order

□ I have a Living Will

□ I have a durable Power of Attorney

□ I have a designated surrogate decision maker – Name:_____

□ Due to my beliefs, I wish not to discuss Advanced Directives at this time.

How did you hear about our office? □ Our Website □ Insurance Company □ ZocDoc □ Physician

□ Internet □ Friend/Relative (who may we thank)_____ □ Other _____