

PODIATRIC REGISTRATION FORM

PATIENT INFORMATION

Name:		
Address:	Home Phone #:	Date:
City:	State:	Zip:
Sex:	SS #:	Birth Date:
Marital Status:	Work Phone Number:	
Occupation:	Spouse's Name:	
Employer:	Spouse's Occupation:	
Employer's Address:	Spouse's Employer:	
Whom may we thank for referring you?		

MEDICAL CONTACT INFORMATION

Contact In Case of Emergency:	Phone Number:
Family Physician:	Phone Number:
Physician Address:	Date of Last Visit:
Primary Pharmacy:	Street / City:

INSURANCE

Person Responsible for this Account:	
Relationship to Patient:	
Primary Insurance Co.:	
Subscriber's Name:	SS #:
Relationship to Patient:	Birth Date:
Secondary Insurance Co.:	
Subscriber's Name:	SS #:
Relationship to Patient:	Birth Date:

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have coverage with the above Insurance Company and assign directly to John E. Bubser, D.P.M. 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 use of this signature on all insurance submissions.

Responsible Party: _____ **Date:** _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to John E. Bubser, D.P.M. for any service furnished to me by the 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 another approved claim form or electronically submitted claim, my signature authorizes the release 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 I am responsible only for deductible, coinsurance and non covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Responsible Party: _____ **Date:** _____

PODIATRIC REGISTRATION FORM - CONTINUED

What is the reason you are seeing the doctor today?

MEDICAL HISTORY: Circle "Yes" or "No" for each problem you have now or have had in the past.

AIDS/HIV	Yes	No	Ear Problems	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Thyroid Disease	Yes	No
Angina	Yes	No	Eye Problems	Yes	No	Respiratory Disease	Yes	No
Arthritis	Yes	No	Foot or Leg Cramps	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Gout	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Attack	Yes	No	Sickle Cell Disease/Trait	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Sinus Problems	Yes	No
Back Problems	Yes	No	Hepatitis or Jaundice	Yes	No	Smoker	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No	Stomach Ulcer	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Swelling in Ankles or Feet	Yes	No
Chronic Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Chronic Headaches	Yes	No	Lyme Disease	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Nervous Problems	Yes	No	Unexplained Weight Loss	Yes	No
Currently Pregnant	Yes	No	Phlebitis	Yes	No	Varicose Veins	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

CURRENT MEDICATIONS: List all medications you are currently taking:

Prescriptions	Prescriptions	Prescriptions

ALLERGIES: Check any allergies that you have now or have had in the past:

ALLERGY CAUSE		
Adhesive Tape		
Aspirin		
Codeine		
Iodine		
Latex		
Local Anesthetics		
Penicillin		
Sulfa Drugs		

SURGICAL HISTORY: List all surgeries you have had and the date you had them:

SURGERY	Date:	SURGERY	Date:

HOSPITAL IN-PATIENT HISTORY: List hospitalizations and dates other than for surgery above:

REASON HOSPITALIZED	Date:

CONSENT

I certify that the information on this form is true and correct to the best of my knowledge. I give my permission to the physician to administer and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet and ankles.

Patient's Signature

Date:

Parent's or Guardian's Signature

Date:

PODIATRIC REGISTRATION FORM - CONTINUED

What is the reason you are seeing the doctor today? _____

MEDICAL HISTORY: Circle "Yes" or "No" for each problem you have now or have had in the past.

AIDS/HIV	Yes	No	Ear Problems	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Thyroid Disease	Yes	No
Angina	Yes	No	Eye Problems	Yes	No	Respiratory Disease	Yes	No
Arthritis	Yes	No	Foot or Leg Cramps	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Gout	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Attack	Yes	No	Sickle Cell Disease/Trait	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Sinus Problems	Yes	No
Back Problems	Yes	No	Hepatitis or Jaundice	Yes	No	Smoker	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No	Stomach Ulcer	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Swelling in Ankles or Feet	Yes	No
Chronic Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Chronic Headaches	Yes	No	Lyme Disease	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Nervous Problems	Yes	No	Unexplained Weight Loss	Yes	No
Currently Pregnant	Yes	No	Phlebitis	Yes	No	Varicose Veins	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

CURRENT MEDICATIONS: List all medications you are currently taking:

Prescriptions	Prescriptions	Prescriptions

ALLERGIES: Check any allergies that you have now or have had in the past:

ALLERGY CAUSE			
Adhesive Tape			
Aspirin			
Codeine			
Iodine			
Latex			
Local Anesthetics			
Penicillin			
Sulfa Drugs			

SURGICAL HISTORY: List all surgeries you have had and the date you had them:

SURGERY	Date:	SURGERY	Date:

HOSPITAL IN-PATIENT HISTORY: List hospitalizations and dates other than for surgery above:

REASON HOSPITALIZED	Date:

CONSENT

I certify that the information on this form is true and correct to the best of my knowledge. I give my permission to the physician to administer and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet and ankles.

Patient's Signature _____

Date: _____

Parent's or Guardian's Signature _____

Date: _____