West Coast
Podiatry, Inc.

# PATIENT REGISTRATION FORM

Date: ______________________ Primary Care Physician: _______________________________________

Patient Name:_________________________________________________ Date of Birth:_________________

Social Security#:____________________ Email: _________________________________________________

Home Address:____________________________________________________________________________

State:________________________ City:________________________ Zip Code:______________________

Mailing Address: ☐Same as Above ______________________________________________________________

Cell Phone:________________________ Alternate Phone: _________________________________________

Sex: ☐ Male ☐ Female ☐ Other: ________________Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated

How did you hear about us: ☐ Friend/Family ☐ Dr. Referral ☐ Website ☐ Other: _______________________

Person completing form: ☐ Patient ☐ Family ☐ Parent ☐ Friend/Caregiver ☐ Other: ____________________

Living Arrangements: ☐ Alone ☐ Family ☐ Group Home ☐ Friend/Caregiver ☐ Assisted Living ☐ Skill Nursing Facility

Employer: _______________________________ Occupation: ___________________ ☐ Retired ☐ Disabled

Emergency Contact:_______________________________ Cell Phone:________________________________

Relationship: _______________________________ Alternative Phone: _______________________________

## INSURANCE INFORMATION

| PRIMARY INSURANCE | ADDITIONAL INSURANCE |
|---|---|
| Name of Insured: ___________________________ | Name of Insured: ___________________________ |
| Insured's Birthdate: _________________________ | Insured's Birthdate: _________________________ |
| Relationship to Patient: ______________________ | Relationship to Patient: ______________________ |
| SS#: _____________________________________ | SS#: _____________________________________ |
| Insurance Name: ____________________________ | Insurance Name: ____________________________ |
| Member Id Number: ________________________ | Member Id Number: ________________________ |
| Group Number: ____________________________ | Group Number: ____________________________ |

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

Signature: _____________________________________________ Date:_______________________________

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# GENERAL MEDICAL INFORMATION FORM

Patient Name:______________________________________________ Date of Birth:_________________

Height: __________________ inches. Weight: _________ lbs.

**Reason for Visit:** ____________________________________________________________________

**Past Medical Information: (check all that apply):** ☐ None

| | | | | | |
|---|---|---|---|---|---|
| | Anemia | | Gastric Reflux/GERD | | Migraine/Headache |
| | Asthma | | Irritable Bowel Syndrome (IBS) | | Mumps/Measles/Chickenpox |
| | Autism | | Gout | | Neurological Disease: |
| | Blood Clots: DVT or PE | | Heart Attacks (MI) | | Osteoarthritis |
| | Cancer: | | Heart Disease | | Osteoporosis |
| | Congestive Heart Failure | | Hepatitis | | Parkinson's Disease |
| | COPD/Emphysema | | High Cholesterol/Hyperlipidemia | | Peripheral Arterial Disease |
| | Coronary Artery Disease | | HIV/AIDS | | Rheumatoid Arthritis |
| | Depression/Anxiety | | High Blood Pressure/HTN | | Skin Disease: |
| | Diabetes Mellitus | | Kidney Disease | | Stroke/CVA/TIA |
| | Enlarged Prostate | | Liver Disease | | Thyroid Disease: |
| | Eczema, Hives, Rashes | | Lung Disease/TB | | Venous Insufficiency |
| | Epilepsy, Seizure | | Mental Illness: | | Other, Please Explain: |
| | Eye Problems: | | Memory Loss/Dementia | | |

**Allergies:** ☐ No Known Allergies ☐ No Food Allergies
Allergies to medications, food, tape, etc. (Please list): ______________________________________
☐ Penicillin ☐Codeine ☐ Sulfa ☐ Iodine ☐ Adhesive ☐ Iodine ☐ Shellfish ☐ Other: ____________________

**Medications (include over the counter, vitamins, supplements):** ☐ None ☐ Yes (List All Medication & Dosages):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Pharmacy (please provide address, phone, and fax):** Pharmacy Name: ______________________________
Address: ______________________________________________________________________
Phone: ________________________________ Fax: _____________________________________

**Surgical History (List All Surgeries):** ☐ None ☐ Appendectomy ☐ Open Heart Surgery ☐ Hysterectomy
☐ Gallbladder Removal ☐ Other: ___________________________________________________
______________________________________________________________________________

**Social History:**
Do you smoke? ☐ No ☐ Former (Quit year_____________) ☐ Yes
☐ Tobacco/Cigar ☐ Cigarettes ☐ Marijuana ☐ E-Cigarette How much & duration: _____________
Do you drink alcohol? ☐ No ☐ Yes ☐ Beer ☐ Wine ☐ Liquor
☐ Socially ☐ Moderate ☐ Heavy How often and how many: ___________________________

Activities/hobbies: _______________________________________________________________

# OFFICE POLICIES & PRIVACY PRACTICES

**OFFICE POLICIES:** Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive, imply some financial responsibility on your part.

**INSURANCE:** We file insurance claims as a courtesy to our patients. We file primary and secondary insurance carriers only. Each individual physician has contracts with various insurance companies. Please check and see if your company is covered by your provider. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you have.

**COPAYMENTS/DEDUCTIBLES:** All Co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Initial: ______________

**PRE-APPROVALS:** You, the patient or the insured is responsible for the initial call to your insurance company, if pre-approval is required. This is the policy of the insurance company. We are responsible for any additional sessions that may be needed for your continued treatment.

**CANCELLATIONS:** We require 24-hour notice on all cancellations so we may have the opportunity to schedule another patient that may need an appointment. Initial: ______________

**PAYMENTS:** We accept the following payment methods: Cash, Check, and VISA/Mastercard. Please let the office know if you have any difficulties in resolving your bill.

**RETURN CHECK FEE:** An additional $25.00 will be added to your statement if the check is returned for insufficient funds. If you have any questions regarding our policies, just let us know. Initial: _____________

**APPOINTMENT REMINDERS:** We can now send you appointment confirmations via phone, text, or email. If you wish to receive these messages we require your consent. I consent to the following: □ Phone □ Text □ Email Initial: ______________
□ I do not consent to have appointment confirmations sent to me.

**ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
I acknowledge that I was provided a copy of the Notice of Privacy and that I have read (or had the opportunity to read if I so choose) and understood the Notice:

Patient Name (please print): ______________________________________________ Date: ______________________________

Parent or Authorized Representative (if applicable): ______________________________________________________________

Signature: _________________________________________________________________________________________________

**AUTHORIZATION AND RELEASE**

I. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third payors and/or other health practitioners.

II. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

III. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor: ______________________________ Date: ______________________