TRI COUNTY FOOT & ANKLE CENTER

Jonathan T. Michael, DPM — The Doctor's Choice for Foot & Ankle Care

- ☐ Bayonne
- ☐ Randolph
- ☐ Jersey City
- ☐ Kearny

PODIATRIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date: _____

Date of Birth: _____**Age:**_____

Patient's Social Security #: _____

Patient's Name(Last name)_____

(First name)_____**(Middle Initial)**_____

Address: _____

City/ST/Zip: _____

Home Phone: _____

Cell Phone: _____

Best time/place to reach you:_____

Email: _____

Gender: ❒Male ❒Female

Marital Status: ❒Married ❒Widowed ❒Single ❒Separated ❒Divorced ❒Partner for ___ years

EMERGENCY CONTACT:

Name:_____

Relationship:_____

Home Phone:_____

Cell/Work Phone:_____

Patient/Parent Employer: _____

Occupation:_____

Employer Address: _____

Employer Phone: _____

Spouses Name: _____

Birthdate:_____

SS#_____

Race: _____(ie White, Asian, Black, Hispanic, Aftrican)

❒I prefer not to answer ❒I don't know

Ethnicity:_____

❒I prefer not to answer ❒I don't know

Preferred Language: _____ ❒I prefer not to answer

Whom may we thank for referring you?_____

INSURANCE DETAIL

PRIMARY INSURANCE INFORMATION

Subscriber's name:_____

Subscriber's SS# _____ **Birthdate:**_____

Relationship to Patient_____

Insurance Company:_____

Insurance ID# _____

SECONDARY INSURANCE INFORMATION

Subscriber's name:_____

Subscriber's SS# _____ **Birthdate:**_____

Relationship to Patient_____

Insurance Company:_____

Insurance ID# _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the following insurance company: _____ and I assign to Tri-County Foot & Ankle Center and/or any of its affiliated doctors, 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Tri-County Foot & Ankle Center and/or any of its affiliated doctors for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

Print Name of Beneficiary,Guardian or Personal Representative _____ **Date:** _____

Signature of Beneficiary, Guardian or Personal Representative:_____**(Relationship to Beneficiary)**_____

MEDICAL HISTORY

Patients Name: _____ Today's Date:_____

ALLERGIES: (please check all that apply):

☐ NO KNOWN ALLERGIES	☐ Codeine	☐ Local Anesthetics	☐ Tylenol/Acetaminophen
☐ Adhesive/Tape	☐ Demerol	☐ Novocaine	☐ Aspirin
☐ Anticoagulant Therapy	☐ Betadine (iodine)	☐ Penicillin	☐ Ibuprofen
☐ Aspirin	☐ Shellfish	☐ Sulfa	☐ OTHER _____
☐			

List Current Prescription Medications *(Please note medication NAME & DOSE)*

_____

_____

_____

_____

Please check yes or no to indicate if you have had any of the following:

AIDS/HIV	❒YES ❒NO	EPILEPSY	❒YES ❒NO	RASH	❒YES ❒NO
ALLERGIES TO ANESTHESIA	❒YES ❒NO	EYE PROBLEMS	❒YES ❒NO	RESPIRATORY DISEASE	❒YES ❒NO
ALLERGIES TO MEDICINE/DRUGS	❒YES ❒NO	FAINTING	❒YES ❒NO	Rheumatic fever	❒YES ❒NO
ANEMIA	❒YES ❒NO	FOOT OR LEG CRAMPS	❒YES ❒NO	Shortness of breath	❒YES ❒NO
ANGINA	❒YES ❒NO	GOUT	❒YES ❒NO	Sinus problems	❒YES ❒NO
ARTHRITIS	❒YES ❒NO	HEADACHES	❒YES ❒NO	Special diet	❒YES ❒NO
ARTIFICIAL HEART VALVES/JOINTS	❒YES ❒NO	HEART DISEASE	❒YES ❒NO	Stroke	❒YES ❒NO
ASTHMA	❒YES ❒NO	HEMOPHILIA	❒YES ❒NO	Swelling in ankles/feet	❒YES ❒NO
BACK PROBLEMS	❒YES ❒NO	HEPATITIS OR JANUNDICE	❒YES ❒NO	Swollen neck glands	❒YES ❒NO
BLEEDING DISORDERS	❒YES ❒NO	HIGH BLOOD PRESSURE	❒YES ❒NO	Tired feet	❒YES ❒NO
CANCER	❒YES ❒NO	KIDNEY PROBLEMS	❒YES ❒NO	Tuberculosis	❒YES ❒NO
CHEMICAL DEPENDENCY	❒YES ❒NO	LIVER DISEASE	❒YES ❒NO	Ulcers	❒YES ❒NO
CHEST PAIN	❒YES ❒NO	LOW BLOOD PRESSURE	❒YES ❒NO	Varicose Veins	❒YES ❒NO
CHRONIC DIARRHEA	❒YES ❒NO	NEUROPATHY	❒YES ❒NO	Venereal Disease	❒YES ❒NO
CIRCULATION PROBLEMS	❒YES ❒NO	PHLEBITIS	❒YES ❒NO	Weight Loss , unintentional	❒YES ❒NO
DIABETES	❒YES ❒NO	PHSYCHIATRIC CARE	❒YES ❒NO	_____	
EAR PROBLEMS	❒YES ❒NO	RADIATION TREATMENT	❒YES ❒NO	_____	

Please list any surgeries/procedures you have had (please note the approximate date):

_____

_____

_____

Hospitalization other than for the surgeries listed:

_____

_____

_____

Smoking Status: (please select which applies): Smoker? ❒Yes ❒Never ❒Former #packs/day_____ # of years_____

Primary Physician: _____ Date of last visit: _____

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:_____

_____

Pharmacy: _____ Pharmacy Phone#:_____

Initial here: _____

Patients Name: _____ *Today's Date:*_____

PODIATRIC HISTORY

What is the chief complaint for which you are seeing the doctor today? (include foot, ankle, knee, thigh and hip complaints):

_____

_____

_____

Have you ever seen to a Podiatrist before: ❒YES ❒NO

If yes, please list: Podiatrist Name:_____ **Last Visit:** _____

Is there any personal or family history of diabetes: ❒YES ❒NO

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	❒LEFT	❒RIGHT ❒BOTH		INGROWN TOENAILS	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
ATHLETES FOOT	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		PLANTAR WARTS	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
BUNIONS	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		SWOLLEN FEET OR ANKLES	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
CORNS/CALLUSES	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		TIRED FEET	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
CRAMPS IN FEET OR LEGS	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		FOOT PAIN	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
NUMBNESS IN FEET OR LEGS	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		OTHER:	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
FLAT FEED	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		_____	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
HEEL PAIN	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH		_____	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH	
FOOT/HEEL ULCER	❒YES ❒NO	❒LEFT	❒RIGHT ❒BOTH						

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA FORM)

I acknowledge that I have been offered/received a copy of the Notice of Privacy Practices & been afforded a means to have any questions answered.

PRIVACY INFORMATION PREFERENCES:

Do you want to be exempt from public reporting?	❒YES ❒NO
Can we send mail to the address on file?	❒YES ❒NO
May we leave a voicemail?	❒YES ❒NO
Will you allow internet-based email or SMS/Text message reminders?	❒YES ❒NO

Who can we leave messages with? _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and doctor's associates, nurses, assistants, or designated replacement) to administer and perform such procedures/diagnostic testing upon me as the doctor deems necessary. I understand that Tri-County Foot & Ankle Center has contractually engaged the services of doctors to provide treatment on its behalf. As such, the treatment I am receiving today may be by a doctor who is an independent contractor, and not an employee of Tri-County Foot & Ankle Center.

Furthermore, I attest that the above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information herein.

_____ _____

Print Name of Beneficiary, Guardian or Personal Representative **Date**

_____ _____

Signature of Beneficiary, Guardian or Personal Representative **(Relationship to Beneficiary)**

FOR OFFICE USE ONLY: *BP* _____ *WEIGHT* _____ *HEIGHT* _____