INDIANA PODIATRY GROUP WELCOMES YOU

PATIENT REGISTRATION FORM

Today's Date:_____ **Account No.**:_____

Patient's Name First:_____ **MI**:_____ **Last**:_____

Date of Birth:___/ ___/ _____ **Age**:_____ **Sex**: M F **Social Security No.**:_____

Address: _____

City:_____ **State**:_____ **Zip Code**:_____

Home Phone:_____ **Work Phone**: _____

Cell Phone:_____ **E-mail**:_____

Ethnicity: (*circle one*) Hispanic Non-Hispanic **Primary Language**:_____
Race: (*circle one*) Caucasian African American Other:_____
Marital Status: (*circle one*) Single Married Divorced Widowed

Patient's Employer:_____ **Phone number**:_____

Employer Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Financial Responsibility - Insurance Policy Holder Information:

Name:_____ **Relationship to Patient**:_____

Date of Birth: ___/ ___/ _____ **Social Security No.**:_____

Address: _____

City:_____ **State**:____ **Zip Code**:_____

Referral Resources

Doctor:_____ Patient:_____ Insurance Provider Directory:_____

Newspaper/Yellow Pages:_____ Health Fair Event:_____

Internet: IPG Website___ Google___ Social Media:_____

Other:_____

Primary Care Doctor: _____

Other Specialists in Your Care:_____

Emergency Contact

Name: _____ **Phone Number**: _____

Relationship to Patient: _____

Indiana Podiatry Group Patient Medical History Form

Name: _____ Date: _____

Please list the foot/ankle problems you are experiencing - please include where and for how long: _____

_____

_____

Previous treatment? _____

Have you seen a podiatrist before? _____

If so, who? _____ Date of Last Visit: _____

Height: _____Weight: _____ Shoe Size:_____

Past Medical History - please circle any current or prior conditions (even if years ago.)

cancer (specify)_____	back pain, hip/knee pain	emphysema
diabetes	fractures (specify)_____	pulmonary embolus
high blood pressure	arthritis	HIV
high cholesterol	sprained ankle/foot	hepatitis
heart attack	rheumatoid arthritis	rheumatic fever
stroke	fibromyalgia	cellulitis or gangrene blood
blood clots	neuromuscular disease	poisoning
poor circulation	frequent urinary infections	polio
leg/foot swelling	kidney disease or dialysis	depression
congestive heart failure	hernia	anxiety
leg/foot numbness	heartburn/reflux	bipolar disorder
burning or tingling	stomach ulcer	developmental abnormality (please specify):
sciatica	jaundice	_____
weakness	pancreatitis	_____
seizures	asthma	_____

Other Conditions: _____

Past Surgical History - please list any and all surgeries you have ever had, not just foot-related, as well as the approximate date performed.

_____

_____

_____

Family Medical History - please list any history of foot/ankle problems, or major medical problems in your close relatives.

_____

_____

Indiana Podiatry Group Patient Medical History Form Cont.

Tobacco Use: Yes/No Packs/day: _____ If previous user, when did you quit? _____

Alcohol Consumption: Yes/No Number of drinks: _____ per day/week/month
(circle frequency)

Illicit drug use current or past: _____

Medications - please list all medications, supplements, herbals, and vitamins you use, as well as what you take them for (if too many please provide a list copy.)

	Name of Medication	Dosage and Frequency	Medical Condition
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

Which pharmacy do you use? _____ Phone#: _____

Allergies - please list all allergies to medicines, chemicals, metals, latex, or foods as well as what happens when you are exposed to these products.

_____

_____

Have you received a flu vaccination ? Yes / No **Date Received** _____

If no, what was the reason? Patient Allergy / Patient Declined / Vaccine Unavailable

For Patients 65 years of age and older:

Do you have a living will or someone designated to make medical decisions on your behalf? Yes / No
Have you had a pneumonia vaccination within the past 10 years? Yes / No

For Patients with Diabetes:

Do you currently own or wear diabetic footwear? Yes / No

If yes, when did you receive your last pair? _____

What was your most recent HgA1C (3 month blood test) result? _____

Date of last result: _____

Indiana Podiatry Group Financial and Privacy Policy Consent Form

Appointments are confirmed by text or email (circle your preference):

Text/SMS Email Other

Phone Messages may be left with (circle your preference):

Patient Only Patient/Spouse Parent/Guardian Anyone answering phone

I Authorize Indiana Podiatry Group to leave appointment information on my (circle your preference):

Home Voicemail Only Cell Voicemail Only Both

Who do you allow us to release your medical information to?

The following individuals are involved in my **medical care/medical information** and can be discussed or given to the following people: (If a friend or relative is NOT listed, information may not be released to them)

_____ _____

(Name of person) **(Relationship to you)**

_____ _____

(Name of person) **(Relationship to you)**

Please initial by each section:

_____ **Cancellation & No Show Policy**

We require a 24 hour notice if you are not able to keep your appointment with our office. First failed appointment, you will receive a call from our office. Second failed appointment, you will be charged a no show fee of $50.00 that is **NOT** filed with your insurance. You will be responsible to pay the charge. Third failed appointment, you may be discharged as a patient in our office.

_____ **Payment and Charges**

Payment is due at time of service. You will be responsible for paying any co-payments, coinsurance, deductibles, non-covered services, or supplies at the time of service. We accept Cash, Check, or Debit/Credit Card. There will be a $25.00 charge for any returned checks. Services will be filed to your insurance. You understand you are liable for any services denied by your insurance carrier. If payment is not made after reasonable notice of any balance due on your account, you will be responsible for any interest charges that can be added at the current legal rate, and all collection effort fees, including attorney and court costs.

There will be a $15.00 charge for forms you request to be completed for FMLA, Disability, or various needs.

Consent

By signing this form, you consent to our use & disclosure of protected health information about you for treatment, payment, and health care operations. I have read the above information, and agree to the policies and procedures of Indiana Podiatry Group, Inc.

Patient Printed Name_____ Patient Signature _____ Date_____
(Guardian)

Witness _____ Date_____