Claymon A. Stevenson II, D.P.M

4000 Annapolis Road #105
Baltimore, MD 21227
P: (410)355-3519 Fax: (410)355-4643

PODIATRY PATIENT REGISTRATION FORM

Name:_____**Gender** _____ **M** _____ **F**
First **M.I.** **Last**

Date of Birth:_____**Age**_____**Social Security #:**_____

Address: _____**City:**_____**State:**___**Zip:**_____

Home Phone #:_____**Work Phone#:**_____**Cell Phone:**_____

Email Address:_____

Emergency Contact: _____**Phone:**_____**Cell Phone:**_____

Employment Status ____**Full-Time** ____**Part-Time** ____**Not Employed**

Student Status ____ **Full-Time** ____**Part-Time** ____**Not a Student**

Race:
American Indian or Alaska Native _____ **Native Hawaiian or another Pacific Islander** _____
Black or African American _____ **Asian** _____ **Caucasian** _____

Ethnicity:
Hispanic or Latino _____ **Not Hispanic or Latino**_____

Primary Care Physician:_____

Cardiologist:_____**Endocrinologist:**_____

Nephrologist:_____**Rheumatologist:**_____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Co-pay amount (specialist)** _____

Subscriber I.D.# _____ **Group#:** _____

Policy Holder's Name _____ **Policy Holder's Date of Birth:**_____

Insured Employer _____ **Effective Date:** _____

Secondary Insurance Company: _____ **Co-pay amount (specialist)** _____

Subscriber I.D. # _____ **Group#:** _____

Policy Holder's Name _____ **Policy Holder's Date of Birth:**_____

Insured Employer _____ **Effective Date:** _____

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ALLERGIES

Please check all allergies:

____ Medications:_____

____Foods:_____

____ Tapes or Topical Skin Sensitivity____ Other:_____

What types of reactions have you experienced?

_____

_____

MEDICATIONS

Please list all medications and the dosages:

1._____ **5.**_____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

PREFERRED PHARMACY

Pharmacy Name:_____

LOCATION: _____**ZIP CODE:**_____**PHONE#:**_____

Personal Medical History:

****Check those that apply to you now or have applied to you in the past****

	Anemia/Blood Disorders		**Hepatitis/HIV**
	Arthritis		**High Blood Pressure**
	Asthma/Hay Fever/Shortness of Breath		**High Cholesterol**
	Blood Clots		**Kidney Disease**
	Chest Pain on Mild Exertion		**Liver Disorder**
	Diabetes - Average Blood Sugar _____ HgbA1C ___		**Pneumonia**
	Dialysis M W F or T TH SA		**Prolonged Bleeding Time**
	Drug/Alcohol Abuse		**Prostate Disorder**
	Ear, Nose, Throat Disorder		**Psychiatric Treatment**
	Emotional Problems/Tension		**Sexually Transmitted Disease**
	Emphysema		**Stomach/Ulcer Disorder**
	Epilepsy or Seizures		**Stroke**
	Gout		**Thyroid/Parathyroid Disease**
	Headaches/Migraines		**Tumor/Abnormal Growth/Cancer**
	Heart Trouble		**Other**

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SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

PATIENT INFORMATION

Do you smoke currently?____Yes ____No How many packs per day? _____ For how many years? _____

Have you smoked previously?___Yes___No When did you quit?_____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

For women only: Are you pregnant? _____ How many months? _____

Please complete the following:

Height: _____ Weight: _____ Shoe size: _____

Occupation: _____

PRIVACY INFORMATION
CHECK ALL THAT APPLY

May we leave appointment and medical information by way of message or email:

Patient Only?	**Y**	**N**	**Patient and/or Spouse?**	**Y**	**N**
Anyone answering home phone?	**Y**	**N**	**On Home Voice Mail ?**	**Y**	**N**
Via E-Mail?	**Y**	**N**	**On C**		
ell Voice Mail?	**Y**	**N**			

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I permit a copy of this assignment to be used in place of the original for purposes of billing.

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The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

_____ _____

DATE **SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

****If not patient, relationship to patient:**
___Parent ___Power of attorney ___Legal Guardian ___ Other: _____

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have read or had the opportunity to read the Health Insurance Portability and Accountability Act of 1996, (HIPPA) and that I understood the Notice.

_____ _____ _____

Patient Name (PLEASE PRINT) **Date** **Patient Signature or Auth. Rep.**

**** If you have not had the opportunity review the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy is available in our office for your review.**