NORTH COAST PODIATRY PATIENT REGISTRATION

PATIENT INFORMATION

* Patient's Last Name	First Name	Middle Initial	* Birthdate (mm/dd/yyyy)

* Nickname (Name I prefer to be called)	* Preferred Pronouns (circle) She / He / They / Other _____ / Prefer not to declare

* Marital Status (circle) Single / Life-Partnered / Married / Divorced / Separated / Widowed	* Name of Significant Other	*Social Security Number _ _ _ - _ _ - _ _ _ _

Street Address	City	State	Zip Code

Send Appointment Reminders by (circle): Text to your mobile phone / Email / Phone Voice Recording	Home Phone Number

Mobile Phone Number	Email Address

Are you retired? (circle) Yes! No	Employer Name	Job Title

Preferred Pharmacy	Primary Care Provider (PCP)	Date of last visit (an estimate is fine)

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Relationship to Patient:

Name of Person Responsible for Bill	Birthdate (mm/dd/yyyy)

Street Address	Social Security Number _ _ _ - _ _ - _ _ _ _

City	State	Zip Code	E-mail

Mobile Phone Number	Home Phone Number	Work Phone Number

Employer	Job Title

INSURANCE ***PLEASE PROVIDE YOUR INSURANCE CARD(S) AND A PHOTO ID TO BE PHOTO COPIED TO YOUR PATIENT CHART***

* Primary Insurance	Subscriber Name	Birthdate (mm/dd/yyyy)	Social Security #

Insurance ID#	Group #	Policy #	Effective Date	Expiration Date	Co-Payment: $

* Secondary Insurance	Subscriber Name	Birthdate (mm/dd/yyyy)	Social Security #

Insurance ID#	Group #	Policy #	Effective Date	Expiration Date	Co-Payment: $

IN CASE OF EMERGENCY

Name of Significant Other or Nearest Friend

Relationship to Patient	Best Phone Number	We are glad you are here!

REFERRAL

How did you learn about us? (Please check all that apply):

Dr. _____ / Hospital/ER / Insurance Plan / Phonebook / Internet / Website / Friend/Family: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to North Coast Podiatry, PC all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges wether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. North Coast Podiatry may use my health care information and may disclose such information to the disclosed 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.

PATIENT / GUARDIAN SIGNATURE **DATE**

PAST MEDICAL HISTORY

Head
- ☐ Trauma
- ☐ Other_____

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wear glasses
- ☐ Other_____

Ears
- ☐ Hearing loss
- ☐ Use of hearing aid(s)
- ☐ Other_____

Nose
- ☐ Allergic Rhinitis
- ☐ Sinus infections
- ☐ Other_____

Mouth/Throat/Teeth
- ☐ Chokes often when eating
- ☐ Wear dentures
- ☐ Other_____

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ Atrial fibrillation
- ☐ CHF
- ☐ Chilblains
- ☐ DVT/Blood clot
- ☐ Dysrhythmia/A fibrillation
- ☐ HTN/High blood pressure
- ☐ Heart murmur
- ☐ Myocardial infarction
- ☐ Other_____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD - Bronchitis/Emphysema
- ☐ Pleuritis
- ☐ Pneumonia
- ☐ Other_____

Gastrointestinal
- ☐ Bowel/Digestive problems
- ☐ Cirrhosis
- ☐ GERD/Indigestion
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis (A, B or C) ____
- ☐ Hiatal Hernia
- ☐ Jaundice
- ☐ Ulcer
- ☐ Other_____

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis/Kidney Stone
- ☐ Other kidney disease
- ☐ STDs
- ☐ UTIs
- ☐ Other_____

Musculoskeletal
- ☐ Arthritis
- ☐ Bone Spur
- ☐ Gout Bronchitis/Emphysema
- ☐ Injury_____
- ☐ Osteoporosis/Osteopenia
- ☐ Other_____

Skin
- ☐ Chronic Ulcer/Wound
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Psoriasis
- ☐ Other_____

Neurological
- ☐ Balance problems
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Frequent headaches
- ☐ Neuroma
- ☐ Parkinson's
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Heart murmur
- ☐ Myocardial infarction
- ☐ Other_____

Psychiatric
- ☐ Addiction Issues
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts
- ☐ Other_____

Endocrine
- ☐ Goiter
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Other_____

Heme/Onc
- ☐ Anemia
- ☐ Bruise easily
- ☐ Cancer
- ☐ Other_____

Infectious
- ☐ Hepatitis (A, B or C) ____
- ☐ HIV
- ☐ STDs
- ☐ Tuberculosis
- ☐ Other_____

PAST SURGICAL PROCEDURES

Common Surgeries
- ☐ Amputations
- ☐ Aneurysm repair
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Bilateral tubal ligation
- ☐ Breast reduction
- ☐ CABG
- ☐ Carotid endarterectomy
- ☐ Carpal tunnel release
- ☐ Cataract/lens surgery
- ☐ Cesarean section
- ☐ Cholecystectomy/Bile
- ☐ Colonoscopy
- ☐ Dilation and curettage
- ☐ Foot surgery
- ☐ Gallbladder removal
- ☐ Gastric bypass
- ☐ Heart surgery
- ☐ Hemorrhoid surgery
- ☐ Hernia
- ☐ Hip arthroplasty
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Inguinal hernia repair
- ☐ Knee arthroplasty
- ☐ Knee replacement
- ☐ LASIK
- ☐ Laminectomy
- ☐ Mastectomy
- ☐ Myasthenia gravis
- ☐ Nasal surgery
- ☐ Osteitis pubis
- ☐ PTCA/PCI
- ☐ Pacemaker/defibrillator
- ☐ Prostate biopsy
- ☐ Prostatectomy
- ☐ Rotator cuff surgery
- ☐ Shoulder surgery
- ☐ Sinus surgery
- ☐ Skin cancer excision
- ☐ Spinal fusion
- ☐ Stent
- ☐ TAH-BSO
- ☐ TURP
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Umbilical Hernia
- ☐ Vasectomy
- ☐ Vascular Surgery
- ☐ _____
- ☐ _____

FAMILY HEALTH HISTORY

Mother Alive/Deceased/Unknown Major Health Concern(s):	**Father** Alive/Deceased/Unknown Major Health Concern(s):	**Sister(s)/Brother(s)** Alive/Deceased/Unknown Major Health Concern(s):	**Children** Alive/Deceased/Unknown Major Health Concern(s):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Tobacco	**Alcohol**	**Caffeine use**	**Drug abuse**
☐ Never smoke ☐ Occasional smoker ☐ Daily smoker ☐ Former smoker Year stopped: _____	☐ Do not drink ☐ Drink occasionally ☐ Frequently drink ☐ Drink daily ☐ History of alcoholism ☐ Other_____	☐ Do not consume caffeine ☐ Consume caffeine occasionally ☐ Consume caffeine daily ☐ Other_____	☐ Do not use illicit drugs ☐ Some illicit drug use ☐ IVDU ☐ Other_____

HOSPITAL ADMISSIONS WITHIN THE LAST 12 MONTHS

Date of Admission	How many days were you in the hospital?	Did you have a surgical procedure? Y/N	Type of procedure

Do you currently reside in a long-term care facility? Y/N _____ **Name of facility** _____

Do you have any implantable devices? (Examples: reconstructive joint replacements, cardiac pacemakers, defibrillators, stents, valves, electrical leads/batteries, and drug delivery systems.) **Y/N** _____ **Type of device** _____

Are you on a blood thinner? Y/N _____ **Name of medication** _____

CURRENT MEDICATIONS

Please include prescribed medications, over-the-counter medications, medicinal herbs, and supplements.

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES TO MEDICATIONS OR FOODS

Allergen	Reaction	Severity (Mild/Moderate/Severe)

HISTORY OF PRESENT FOOT PROBLEM

What foot ailment brings you in today? _____

Where on your feet is the most painful? _____

How long have you been having the problem? _____

How did the problem occur? Slow onset or acute injury? _____

Please continue to the next page (CONSENT FOR TREATMENT) after reviewing the NOTICE OF PATIENT RIGHTS, NOTICE OF PRIVACY PRACTICES and FINANCIAL POLICY included with these forms. Please feel free to keep the policy pages for your records.

NORTH COAST PODIATRY

Joseph T. Breen, D.P.M.

3798 Janes Rd Suite #9
Arcata, CA 95521

Office: (707) 599-8677
Fax: (707) 599-8176

CONSENT FOR TREATMENT

Patient Consent

I hereby voluntarily consent to outpatient care by North Coast Podiatry, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by North Coast Podiatry. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

Consent to View External Prescription History

I authorize North Coast Podiatry to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit manager's may be viewable by my provider and staff at North Coast Podiatry and it may include prescriptions back in time for several years.

Patient Initials: _____

Insurance Assignments and Release

I certify that I have insurance with the insurance company(ies) disclosed and a sign directly to North Coast Podiatry and its Podiatrist(s) all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agreed that should my account becomes delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorized the use of my signature below on all insurance submissions.

Patient Initials: _____

Use of Information

North Coast Podiatry may use my healthcare information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits are the benefits payable for related services.

Patient Initials: _____

Authorization Regarding Privacy Policy

Due to the recent implementation of the patient privacy act (HIPPA), I hereby authorize North Coast Podiatry to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or change appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: _____

Acknowledgment of Receipt of Privacy Practices

I acknowledge that I was provided a copy of the North Coast Podiatry **Notice of Privacy Practices** and that I have read (or have had the opportunity to read and ask questions for clarification if I so chose) and I understand the notice.

Patient Initials: _____

Acknowledgment of Receipt of Patient Rights

I acknowledge that I was provided a copy of the North Coast Podiatry **Notice of Patient Rights** and that I have read (or have had the opportunity to read and ask questions for clarification if I so chose) and I understand the notice.

Patient Initials: _____

Acknowledgment of Receipt of Financial Policy

I acknowledge that I was provided a copy of North Coast Podiatry **Financial Policy** and that I have read (or have had the opportunity to read and ask questions for clarification if I so chose), I understand, and will comply by the policy stated.

Patient Initials: _____

*****I have read and fully understand this Consent for Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a North Coast Podiatry patient. I have read this complete form and agree to all of its contents.**

_____ _____ _____

Name of Individual/Legal Representative (Print) **Signature of Individual/Legal Representative** **Date**