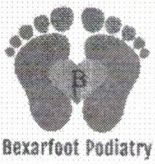

Bexarfoot Podiatry

Patient Registration Form

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card/ID)
Sex	Date of Birth	Social Security Number
Patient's Address	City	State/Zip
Home Phone	Mobile Phone	Email Address
Referred By	Primary Care Physician	Primary Care Physician Phone
Pharmacy	Pharmacy Phone	Pharmacy Address
Email Address	Marital Status	

Patient Employer

Employer	Occupation	Employer Phone
Employer Address	City	State/Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Number	Relation to Patient

Primary Insurance

Primary Health Insurance Company	Plan
Plan ID Number	Group Number
Policy Holder's Name (as it appears on the card or ID)	Relation to Patient
Policy Holder's Address	City/State/Zip
Policy Holder's Birthday	Policy Holder's Phone Number

Secondary Insurance

Secondary Health Insurance Company	Plan
Plan ID Number	Group Number
Policy Holder's Name (as it appears on the card or ID)	Relation to Patient
Policy Holder's Address	City/State/Zip
Policy Holder's Birthday	Policy Holder's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient
Address	City	State/Zip

Reason for Visit/What brings you to the office today?

_____

_____

Please describe any previous treatment and/or care you have received for this problem.

_____

_____

Pain Assessment/Please indicate your level of pain on a scale of 1-10 by circling it. (10=worst pain imaginable)
1 2 3 4 5 6 7 8 9 10

Check the symptoms that best describe your problem.
___Stiffness ___Pain ___Instability ___Swelling ___Numbness ___Other:_____

Are you symptoms getting...
___Better Gradually ___Worse Gradually ___Better Rapidly ___Worse Rapidly

What improves your symptoms?
___Rest ___Ice ___Heat ___Motrin/Aleve ___Other:_____

Do you have any of the following? Please indicate each problem below by checking it.

___Ankle sprain___Arch pain___Athlete's foot___Broken Ankle___Bunions___Bunions___Burning sensation in feet
___Corns/Calluses___Cramps in feet___Cramps in legs___Enlarged veins___Flat feet___Foot numbness___Foot ulcers
___Fungal toenails___High arch feet___Heel pain___Hammer toe___Ingrown nail___In-toeing___Knee pain___Leg ulcer
___Loss of sensation to feet___Lower back pain___Rash on feet___Swelling in ankles___Swelling in feet___Swelling in legs___Tingling in feet

Do you currently or have you ever worn orthotics?

___Yes ___No

Does your foot pain limit your desired activity?

___Yes ___No

Are your first steps out of bed in the morning painful?

___Yes ___No

Have you ever had any other foot problems?

___Yes ___No **If so, please describe:**_____

Lifestyle Factors
Have you ever smoked?
___Yes ___No **# of years**_____**#packs per day**_____

Do you currently smoke?
___Yes ___No **# of packs per day**_____

Do you use recreational drugs?
___Yes ___No **types?**_____ **# of times per week**_____

How much alcohol do you drink per week?
# of drinks per week_____

How many hours a day do you stand?
# of hours_____

Please list any surgeries you have had and the dates of those surgeries.

Please list any medications (prescription and non-prescription) that you are taking.

Do you have any allergies to medications, foods or environmental factors? If so, please list them below.

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Joint Disorder
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Details:

Review of Systems (Please X if you HAVE these.)

Allergic/Immunologic
__seasonal allergies __sensitivity to dust
__coughing

Constitutional Symptoms
__sleep problems __fever
__dizziness __headache
__faintness

Endocrine
__dry hair __cold intolerance
__weight changes

Gastrointestinal
__abdominal pain __heartburn
__blood in stool

Hematologic/Lymphatic
__ankle/foot edema __calf pain
__bruise easily __bleeding problems

Musculoskeletal
__back pain __joint swelling
__heel pain __muscle pain
__hip pain __neck pain
__joint pain __stiffness

Respiratory
__difficulty breathing __shortness of breath
__chest tightness
__snoring

Cardiovascular
__arm pain __high blood pressure
__chest pain __chest pressure
__cold hands __cold feet
__calf cramping

Ear, Nose, Mouth, Throat
__hearing loss __sore throat
__blisters in mouth __sinus problem

Eyes
__dry eyes __itchy eyes
__excess tearing __glaucoma
__macular degeneration

Genitourinary
__currently pregnant __painful urination
__on dialysys

Integumentary
__athletes foot __discoloration
__cyst __leg swelling
__dry, scaly skin __lower leg ulcers

Neurological
__dizziness __migraines
__confusion __seizures
__forgetfulness __tingling
__headache __tremors

Bexarfoot Podiatry

Patient Consent for Use of Protected Health Information and Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I have a right to request a copy of the Notice of Privacy Practices prior to signing this consent. A copy will be provided to me by Bexarfoot Podiatry PLLC upon request, in person, by phone or on our website at www.bexarfoot.com.

I understand that Bexarfoot Podiatry PLLC may use or disclose my protected health information for treatment, payment or health care operations by means of providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Bexarfoot Podiatry PLLC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I have the right to revoke this consent in writing at any time, except to the extent that Bexarfoot Podiatry PLLC has taken action relying on this consent.

_____

Printed Name of Patient/Legal Guardian

_____

Signature of Patient/Legal Guardian

Bexarfoot Podiatry

PLLC

OFFICE POLICIES

CANCELLATIONS: We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the $50.00 no show fee.

TARDINESS: If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment times.

MEDICAL RECORDS: There is a $25.00 fee for release of medical records. This must be paid prior to the release of records as it helps cover the cost of printing and shipping. Please allow one week to process your request.

COMPLETION OF FORMS: Our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days. Fee for forms are as follows: FMLA $50.00. Handicap Placard $5.00.

I have read and understand the policies set forth by Bexarfoot Podiatry PLLC.

_____ _____

Patient/Legal Guardian Date

Bexarfoot Podiatry

I understand that the information sent to me via email and/or via text message from persons at Bexarfoot Podiatry PLLC will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my PHI (Protected Health Information) may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that Bexarfoot Podiatry PLLC and its staff are not responsible for any unauthorized access of my PHI communicated by way of unencrypted email and text and that I bear the risk.

Patient Name/Guardian Name: _____

PatientSignature/Guardian Signature: _____

Date: _____