PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Patient: _____
Last First MI

Address: _____

_____
City State Zip

E-Mail Address: _____

Sex: ___ M ___F **Age:**_____ **Birthday:**_____

___Single ___ Married ___Widowed ___ Separated ___ Divorced

Patient SS # _____ **Race** _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthday: _____ **SS#** _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co _____

Member # _____ **Group #** _____

Is Patient covered by Additional Insurance? ___ **Yes** ___ **No**

Subscriber Name _____

Birthdate _____ **SS #** _____

Relationship to Patient _____

Insurance Co. _____

Member # _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Joseph Strickland, DPM/Dr. Sarah Strickland, DPM 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 Hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature _____

Relationship _____ **Date** _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Strickland for any services rendered me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible on for the deductible, coinsurance, and non-covered services. coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____ **Date**_____

3 PHONE NUMBERS

Home #_____ **Cell** _____

Work # _____ **Ext** _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____**Relationship**_____

Home # _____ **Work #** _____**Ext** _____

4 PODIATRIC HISTORY

Describe the chief complaint to be treated. (Include foot, ankle, knee, thigh and hip)

_____

_____

_____

Have you been to a Podiatrist? ___ Y ___N

Dr._____ **When**_____

Is there any personal or family history of diabetes? ____ Yes ____No

Your occupation _____

Cigarette/Tobacco __Y __N Yrs _____

Athletic activities & frequency

_____

_____

Indicate the foot problems you have or have had in the past.

Ankle pain	**___Y ___N**
Athlete's foot	**___Y ___N**
Bunions	**___Y ___N**
Corns & Calluses	**___Y ___N**
Numbness in feet or legs	**___Y ___N**
Flat feet	**___Y ___N**
Cramps in feet or legs	**___Y ___N**
Heel pain	**___Y ___N**
Ingrown toenails	**___Y ___N**
Plantar warts	**___Y ___N**
Swelling ankles & feet	**___Y ___N**
Tired feet	**___Y ___N**

5 MEDICAL HISTORY

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	___Y ___N	Diabetes	___Y ___N	Psychiatric Care	___Y ___N
Allergies to Anesthesia	___Y ___N	Ear Problems	___Y ___N	Radiation Treatment	___Y ___N
Allergies to Medicine /Drugs	___Y ___N	Epilepsy	___Y ___N	Rash	___Y ___N
Anemia	___Y ___N	Eye Problems	___Y ___N	Respiratory Disease	___Y ___N
Angina	___Y ___N	Fainting	___Y ___N	Rheumatic Fever	___Y ___N
Arthritis	___Y ___N	Gout	___Y ___N	Shortness of Breath	___Y ___N
Artificial Heart Valves/Joints	___Y ___N	Headaches	___Y ___N	Sinus Problems	___Y ___N
Asthma	___Y ___N	Heart Disease	___Y ___N	Special Diet	___Y ___N
Back Problems	___Y ___N	Hemophilia	___Y ___N	Stroke	___Y ___N
Bleeding Disorders	___Y ___N	Hepatitis or Jaundice	___Y ___N	Swollen Neck Glands	___Y ___N
Cancer	___Y ___N	High Blood Pressure	___Y ___N	Tuberculosis	___Y ___N
Chemical Dependency	___Y ___N	Kidney Problems	___Y ___N	Ulcers	___Y ___N
Chest Pain	___Y ___N	Liver Disease	___Y ___N	Varicose Veins	___Y ___N
Chronic Diarrhea	___Y ___N	Low Blood Pressure	___Y ___N	Venereal Disease	___Y ___N
Circulatory Problems	___Y ___N	Nervous Problems	___Y ___N	Unexplained Weight Loss	___Y ___N
		Phlebitis	___Y ___N		

PAST SURGERIES: _____

_____

_____

HOSPITALIZATION OTHER THAN SURGERIES LISTED: _____

_____

FAMILY PHYSICIAN: _____ **PHONE #** _____ **LAST VISIT:** _____

ARE YOU NOW, OR HAVE BEEN, UNDER ANY OTHER DOCTORS CARE FOR ANY REASON OVER THE PAST TWO YEARS? ___Y ___N

IF YES, PLEASE EXPLAIN _____

B/P _____ **HEIGHT** _____ **WEIGHT** _____ **SHOE SIZE** _____

6 MEDICATIONS & DOSAGE

INCLUDE PRESCRIPTION, OVER-THE-COUNTER AND VITAMINS:

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone # _____

Are you on Oral Contraceptives? ___ Y ___ N

7 ALLERGIES

___ Codeine _____
___ Aspirin _____
___ Sulfa _____
___ Penicillin _____
___ Iodine _____
___ Novocain _____
___ Seafood _____
Other:
_____ _____
_____ _____
_____ _____
_____ _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ **Date** _____

Joseph H. Strickland, D.P.M.
Sarah L. Strickland, D.P.M.

Podiatric Physicians and Surgeons

9371 U.S. Hwy.19 N., Suite B
Pinellas Park, FL 33782
(727) 579-0441

7926 W. Hillsborough Ave., Suite G
Tampa, FL 33615
(813) 887-1980

Fax (727) 576-8955

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATION.

By signing this consent, I acknowledge and agree as follows:

I acknowledge that I was offered the opportunity to read a copy of the Notice of Privacy Practices and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: To telephone my home or to leave a message on my answering machine, or with the individual answering the phone.

The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that the Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me. I understand that I do not sign this Consent evidencing my consent to the uses and disclosures described to be above contained in the Privacy Notice, and then the Practice will not treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Authorization to Share Private Health Care Information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Joseph H. Strickland, D.P.M.

Sarah L. Strickland, D.P.M.

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FINANCIAL AGREEMENT

Dear Patient,

Thank you for choosing Dr. Joseph H. Strickland, D.P.M/Dr. Sarah L. Strickland, D.P.M. as your podiatric health care provider. We are committed to the success of your treatment as well as providing you the best possible podiatric care. Please understand that payment of your bill is considered a part of your treatment All patients must complete our Patient Registration form before seeing Dr. Strickland. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.

Regarding Medicare

We are a Medicare provider therefore we do accept assignment on Medicare. When possible your claim will be filed to Medicare and any supplemental insurance that routinely pays the doctor for his services. For those patients that have a supplemental that does not routinely pay the doctor or if you do not have a supplemental policy, we will require 20% of the bill to be paid at the time of service. If there is a remaining balance after your insurance pays, then a bill will be sent to you, for your payment of the final balance. Please be aware that some, and perhaps all of the service provided may be non-covered services and not considered medically necessary under the Medicare Program. Our staff recognized this and will attempt to take the time to discuss these charges with our prior to a service.

If you are a member of an insurance company that we are not participating with, we ask that you pay the full amount of the visit at the time of service. We will provide you a copy of your bill or help fill out a claim form so you can submit it to your insurance company.

Miscellaneous Policies

24 hour notice may not always be possible but please call as soon as you realize you will not be able to make your appointment. Thank you for your understanding and cooperation.
Minors must be accompanied by a parent or legal guardian.
Returned checks are subject to a $35.00 processing fee.
All accounts must be paid upon receipt of our bill. Payment options are available.

If you have any questions about the above information we will be glad to answer any questions.

I have read the Financial Agreement I understand and agree to the Financial Agreement.

I, the undersigned, authorize payment of medical and surgical benefits directly to Joseph H. Strickland, D.P.M/Dr. Sarah L. Strickland, D.P.M. and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Joseph H. Strickland, D.P.M./Dr. Sarah L. Strickland, D.P.M. all rights to inquire on my behalf of any medical reviews relating to my medical benefits, either assigned or non-assigned claims.

_____ X_____

Patient Name (Printed) Signature of Patient/Responsible Party Date