PATIENT REGISTRATION

Patient Information

Name _____
Last First M Initial

Address _____
Street Apt

_____
City State Zip

_____
Home Phone Work Phone Cell Phone

Date of Birth: ___ /___ /___ Age: _____

SS #: _____ - _____ - _____ Sex ___ M ___ F

Marital Status ___ S ___ M ___ D ___ W

Driver's License # _____

Name of Spouse _____

_____
Emergency Phone No. Emergency Contact

Patient's Employer

Employer _____

Occupation _____

Address _____

City _____ State ___ Zip _____

Phone Number _____

Primary Insurance

Insurance Company _____

Address _____

City _____ State ___ Zip _____

Phone No. _____

Policy No. _____ Group No. _____

Secondary Insurance

Insurance Company _____

Address _____

City _____ State ___ Zip _____

Policy No. _____ Group No. _____

Phone No. _____

Who may we thank for referring you to our office?
Referred by: _____

Patient's Spouse/Guardian/Guarantor

Name: _____

Address: _____

City _____ State ___ Zip _____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Social Security Number: _____

Date of Birth ___ /___ /___ DL# _____

Guarantor's Employer

Employer: _____

Occupation: _____

Address: _____

City: _____ State ___ Zip _____

Phone No. _____

ASSIGNMENTS OF BENEFITS:
I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

_____ _____
Signature Date

RELEASE OF INFORMATION:
I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance company.

_____ _____
Signature Date

AUTHORIZATION OF MEDICAL TREATMENT:
I hereby consent and authorize the Physician and any associate or associates or consultants of his/her choice to provide medical treatment for the above patient.

_____ _____
Signature Date

Please provide us with your insurance, Medicaid, and/or Medicare Cards along with your Driver's License.

_____
Primary Care Physician Phone No.

_____
Pharmacy Name Phone No.

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Previous Surgical History: _____

_____

List of Medications and M.G.: _____

_____

_____

Allergies: ❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Latex ❑ Lortab ❑ Tylenol ❑ Ceftin
❑ Levaquin ❑ Azithromycin ❑ Lidocaine ❑ Anti-Inflammatory ❑ Other _____

Cadiovascular (CV): ❑ High Blood Pressure ❑ Stent ❑ Pacemaker ❑ CHF ❑ Heart Bypass
❑ Blood Clot ❑ Varicose Veins ❑ PVD ❑ Other _____

Endocrine: ❑ Diabetes ❑ Dialysis ❑ Hyperglycemia ❑ Hypothyroid ❑ Hyperthyroid
❑ Hepatitis ❑ Gout ❑ Other _____

ENMT: ❑ Hearing Aid ❑ Hearing Loss ❑ Hard of Hearing ❑ Other _____

Eyes: ❑ Glasses ❑ Contacts ❑ Eye Implant ❑ Other _____

Gastrointestinal (GI): ❑ Heartburn ❑ IBS ❑ Stomach Ulcer ❑ Other _____

Genitourinary (GU): ❑ Kidney Problem ❑ Prostate Cancer ❑ Other _____

Immunologic: ❑ HIV ❑ AIDS ❑ Seasonal Allergies ❑ Other _____

Integumentary: ❑ Thick Nails ❑ Fungus Nail ❑ Itchy Skin ❑ Ulcer ❑ Eczema ❑ Dermatitis
❑ Athlete's Foot ❑ Skin Cancer ❑ Cellulitis ❑ Dry Skin ❑ Non-Healing Wound
❑ Other _____

Lymphatic: ❑ Swelling ❑ Other _____

Musculoskeletal: ❑ Bunion ❑ Heel Pain ❑ Hammertoe ❑ Ankle Pain ❑ Toe Pain ❑ Corns
❑ Callus ❑ Other _____

Neurological: ❑ Diabetic Neuropathy ❑ Burning ❑ Neuroma ❑ Tingling ❑ Alzheimer's
❑ Other _____

Psychiatric: ❑ Depression ❑ ADD ❑ Bi-Polar ❑ Panic Attacks ❑ Down's Syndrome
❑ Other _____

Respiratory: ❑ Asthma ❑ COPD ❑ Breathing Difficulties ❑ Emphysema ❑ Lung Cancer
❑ Other _____

Psychiatric: ❑ Yes ❑ No

Smoke: ❑ Yes ❑ No ❑ Quit

Alcohol: ❑ Yes ❑ No ❑ Quit

Shoe Size: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your foot care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing the doctor.

REGARDING INSURANCE

We may accept assignment of insurance benefits however, be aware that the charges, whether your insurance company pays or not, **IS YOUR RESPONSIBILITY**. We cannot bill your insurance unless you give us your insurance information. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT. Please be aware that some, and perhaps all, of the services provided may **NOT** be covered under your insurance plan. It is very important to know and understand your insurance benefits and what your responsibility is prior to visiting your physician.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and verify the accuracy of the information given. I assign insurance benefits directly to Dr. Paul W. Hutchison, if any, otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ALLOWED BY, BUT NOT COVERED BY MY INSURANCE PLAN, INCLUDING DEDUCTIBLES, CO-PAYMENTS AND NON-COVERED SERVICES.** I hereby authorize the doctor to release all necessary information to secure payment of benefits and authorize use of this signature on all insurance submissions. I AM AWARE THAT IF MY ACCOUNT GOES TO COLLECTIONS, I AM RESPONSIBLE FOR ALL COLLECTION AND/OR ALL LEGAL FEES.

Authorized Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practice of the Medical Practice

Signature: _____ Date: _____

Date of Birth: _____ SSN: _____

Signature of Personal Representative: _____

Relationship: _____