ALPINE FOOT SPECIALISTS, P.C.
REGISTRATION

Date_____ Home Phone_____ Cell Phone_____ E-Mail_____

Patient_____
Last Name First Name Initial

Street Address_____

City _____ State_____ Zip_____

Sex ☐ M ☐ F Age____ Birth Date___/___/_____ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security #_____ Driver's License #_____

Student ☐ Full-time ☐ Part-time Whom may we thank for referring you? _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Contact in Case of Emergency _____ Phone # _____

PATIENT'S EMPLOYER

Company Name_____ Occupation_____

Address_____ Work Phone_____ ☐ Full-time ☐ Part-time

City_____ State_____ Zip_____

PRIMARY INSURANCE INFORMATION

Name_____ Birth Date_____/_____/_____
Last Name First Name Initial

Policy/Group#_____ ID#_____ Social Security #_____

Employer's Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

ADDITIONAL INSURANCE INFORMATION

Is Patient covered by other insurance? ☐ Yes ☐ No Name Insurance Co._____

Name of Insured_____ Ins. Birth Date_____

ID#_____ Policy/Group#_____

PATIENT BILLING INFORMATION

Name_____ Relationship_____

Street Address_____ Home Phone_____

City_____ State_____ Zip_____

MEDICAL AND LEGAL INFORMATION

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?

☐ Yes ☐ No Your Initials:_____

Attorney_____ Telephone_____

Address_____

PATIENT AGREEMENT

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to David A. Charnota, D.P.M., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process the claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against may insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured/ Guardian Date

MEDICAL HISTORY FORM

PRESENT ILLNESS OR INJURY

What is the reason (problem) for your visit to our office?

_____

_____

Who is your Primary Care Physician? (i.e. internist)

Name _____ Phone #: _____

Address _____

Have you seen this or any another physician regarding this problem? ☐ YES ☐ NO

If Yes, please list: Doctor _____

SURGICAL/INJURY HISTORY

List the type of surgery and date:

_____

_____

List any injuries that required medical attention or hospitalization and the date:

_____

_____

PHARMACY

What is your preferred pharmacy?

Name: _____

Location: _____ Phone #: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of patient, guarantor or responsible party **Relationship to Patient**

_____ _____

Print name of person whose signature appears **Date**

PATIENT HISTORY FORM

Patient Name Date _____

_____

Height Weight _____ Shoes Size _____ Blood Pressure/ Pulse _____

_____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

SOCIAL HISTORY (Circle one for each that apply below)

Tobacco Use: Every day smoker/ occasional smoker / heavy smoker / never smoked / former smoker

Year started smoking _____ Year quit _____ Are you pregnant? Y N

Alcohol Use: How many drinks per week? _____ History of alcoholism? Y N History of drug use? Y N

MEDICATIONS (list all current medications and dosages – including non-prescription/over the counter medication)

_____

_____

_____

ALLERGIES – MEDICATION/ENVIRONMENTAL

☐ No Known Allergies	☐ Penicillin	☐ Sulfa	☐ Tetracycline	☐ Codeine	☐ Adhesive Tape	☐ Latex
☐ Iodine/Betadine/Shellfish	☐ Radiographic Dyes	☐ Non-steroidal Anti-inflammatories (Advil, Motrin, Aleve)				

Other _____

Type of Reaction _____

PAST MEDICAL HISTORY (circle all that apply)

Anemia Arthritis (Osteoarthritis) Arthritis (Rheumatoid) Asthma Blood Disorder Back Pain

Blood Clots Cancer COPD Gout Heart Disease Hepatitis (B or C) HIV+/AIDS

High Blood Pressure Kidney Disease Neurological Disorder Reflux Seizures Strokes

Thyroid Problem Stomach Ulcers Diabetes – Last Blood Sugar_____ AIC _____

Other_____

FAMILY HISTORY of MEDICAL PROBLEMS

Alcoholism Asthma Blood Disorder Cancer Diabetes Heart Disease Hepatitis

High Blood Pressure Kidney Disease Neurological Disease Seizures Strokes Thyroid Problems

Foot Issues _____ Other _____