PATIENT REGISTRATION INFORMATION

Last Name _____ First Name_____ MI _____

Date of Birth_____ Sex: M / F Age_____ Social Security # _____

Cell Phone _____ Home Phone _____ Work Phone _____

E-mail _____ Preferred Method of Contact (circle one) Cell / Home / Work / Email / Mail

Address _____

City_____State_____Zip_____

Employer _____ Work Status : Full Time Part Time Student

Spouse's Name _____ Social Security # _____

Parent/Guardian Name (for child) _____ Social Security # _____

PERSON TO RECEIVE BILLS OR RESPONSIBLE PARTY (Complete if different than above)

Last Name_____ First Name _____ MI _____

Address_____ City _____ State _____ Zip _____

Primary Phone _____Social Security # _____ Date of Birth_____ Sex: M/F

(Questions required by government/Insurance)

Marital Status: **M S D W** Primary Language: _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Race: White / Black or African American / Asian / American Indian or Alaska Native / Native Hawaiian or Other Pacific Islander

Primary Care Physician _____Diabetic Care Physician _____

Address _____ Phone _____

Pharmacy Name _____ Pharmacy Phone # _____

HOW WERE YOU REFERRED TO OUR OFFICE (PLEASE SPECIFY) _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information

Primary Ins. _____ Secondary Ins. _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO SEE A PROVIDER WHO PARTICIPATES WITH MY INSURANCE AND I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY CHARGES DENIED IF COMMONWEALTH FOOT AND ANKLE IS NOT A PARTICIPATING PROVIDER. I authorize **Commonwealth Foot and Ankle Center** to release any and all information acquired in the course of my treatment to my insurance company and to all medical providers participating in my health care. I authorize payment of medical benefits directly to **Commonwealth Foot and Ankle Center** and accept full responsibility for all charges not paid by my insurance.

Signature _____ **Date** _____

Patient/Parent/ Guardian

Commonwealth Foot and Ankle Center
1915 Bishop Lane
Louisville, KY 40218

Benjamin M. Schaffer, DPM
David Kyle, DPM
Evan Ross, DPM

I hereby acknowledge that I have been advised of the "no show" policy for Commonwealth Foot and Ankle Center, PSC. I further understand that if I do not contact this office within 24 hours of my appointment to advise of my cancellation, I will incur a $25.00 fee.

Please note on all accounts 90 days past due, interest may be charged at a rate of 1.5 % per month and 18% per year. If you do not pay your bill or make payment arrangements and your account goes over 120 days past due, you may be subject to collections.

"Consent to Telephone calls or emails. If at any time I provide a telephone number or email at which I may be contacted, I consent to receive calls, text messages, or emails including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

_____
Print name

_____
Patient signature **Date**

_____
Witness **Date**

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PIRVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

ALSO

I also give permission for Commonwealth Foot and Ankle Center, P.S.C., Benjamin M. Schaffer, D.P.M., David A. Kyle, D.P.M. *or* Evan M. Ross, D.P.M. to release information to the following:

Name	Relationship to patient	Type of info to be released
Name	Relationship to patient	Type of info to be released
Name	Relationship to patient	Type of info to be released
Name	Relationship to patient	Type of info to be released

The type of information to be released:

Medical

Insurance

All

Other (please specify)

*****This authorization is valid until further notice*****

Patient Name (please print)

Parent or Authorization Representative - if applicable (please print)

Signature

Date

For office use:
___New Patient
___ Update

Medical History

Today's Date _____ Primary Doctor (PCP) _____ Diabetes Doctor _____

Last Name _____ First Name _____ MI _____

Date of Birth _____ Height _____ Weight _____ Shoe Size _____

Are you pregnant? Yes No If yes, how far along? _____
Are you diabetic? Yes No If yes, how many years? _____ Average blood sugar _____
Are you on insulin? Yes No If yes, how long have you been on insulin? _____

Do you have, or have you ever been treated for:

Cardiovascular
- □ Angina
- □ Artificial or leaking valve
- □ Blood clots in legs/phlebitis
- □ Congestive heart failure
- □ Coronary artery disease
- □ Heart attack
- □ High blood pressure
- □ Irregular heart beat
- □ Stroke
- □ Valve prolapse
- □ Other_____

Respiratory
- □ Asthma
- □ Bronchitis
- □ COPD
- □ Pneumonia
- □ Tuberculosis
- □ Other_____

Musculoskeletal
- □ Arthritis
  Type_____
- □ Back problems
- □ Fibromyalgia
- □ Gout
- □ Osteoporosis
- □ Other_____

Digestive
- □ Colitis
- □ Cirrhosis
- □ Hiatal hernia
- □ IBS
- □ Reflux
- □ Ulcers
- □ Other_____

Urinary
- □ Kidney stones
- □ Renal failure

Integumentary
- □ Keloid/thick scar
- □ Leg or foot ulcers
- □ Other_____

Neurological
- □ Epilepsy
- □ Migraines
- □ Multiple Sclerosis
- □ Paralysis
- □ Seizures
- □ Other_____

Psychiatric
- □ ADD/ADHD
- □ Addiction _____
- □ Alzheimer's
- □ Bipolar
- □ Dementia
- □ Depression
- □ Schizophrenia

Miscellaneous
- □ Anemia
- □ Cancer
  Type_____
  Year_____
  Treatment_____
- □ HIV or AIDS
- □ Hepatitis (A, B or C)
- □ Thyroid problems
- □ Other_____

Problems not listed above
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____

Please list any medications you are currently taking: (or attach list)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any medications you are "ALLERGIC" TO: ☐ Check if no known drug allergies

_____ _____ _____
_____ _____ _____

Do you smoke? □ Yes □ No How may pack per day? _____
Do you drink alcohol? □ Yes □ No How many do you drink a day?_____

Surgeries:

_____ Year _____ _____ Year _____
_____ Year _____ _____ Year _____
_____ Year _____ _____ Year _____

List any immediate family members who have had
(ex: mom, dad, sister, brother, grandparent, daughter)

Arthritis_____ Foot Problems _____
Birth defects _____ High Blood Pressure _____
Cancer_____ Stroke _____
Diabetes _____ Other significant problems _____

For office use:
__ New Patient
__ Update

Please explain your foot condition

What are you coming in for today? _____

_____

_____

Which foot is bothering you? (circle one) Left Right Both

How long have the problems existed? _____

What symptoms are you experiencing? _____

_____

_____

Are your symptoms: (circle one) Mild Moderate Severe

Does your pain follow any pattern? (Worse in the morning, when walking,etc. And explain)

_____

_____

What have you done so far to treat the problem?
Change Shoe Type __ Pads __ Exercise __ Medicine __
(Please explain) _____

_____

Have you consulted a doctor for this condition? (circle one) Yes No

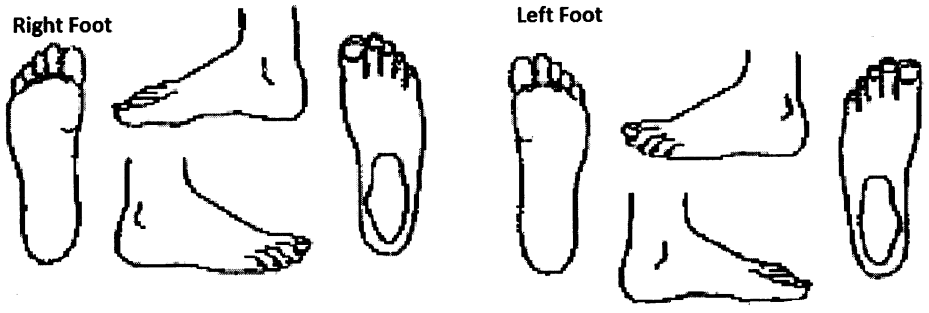
Who is the doctor and what did they say? _____

_____

_____

Do you need preventive antibiotics when having your teeth cleaned? _____

Please use this diagram to tell us the location of your foot problem.



SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as states in more detail in the Notice of Privacy Practices. We will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposed of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas or as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access or and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made on your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.