PATIENT REGISTRATION

Today's Date _____

Last Name _____ First Name _____

Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

SS# _____ Date of Birth _____ Age _____ Sex ( ) Male ( ) Female

Marital Status (check one): ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Race: ( ) Asian ( ) Black/African American ( )White ( ) Native Hawaiian or Pacific Islander ( )American Indian or Alaska Native ( ) Refuse to tell or other

Ethnicity: ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Refused to tell

Preferred language: ( ) English ( ) Spanish ( ) Other _____

Living Arrangements (please check all that apply):
At Home: ___ alone ___with spouse ____with family ____with housemate ____with aides
Other: ____ Nursing Facility ____ Retirement Community

Who may we thank for referring you to us? _____Phone _____

Who is your Primary Care Physician? _____ Phone _____

Physician's Address _____

Are you currently working? ( ) Yes ( ) No Retired? ( ) Yes ( ) No Last date worked? _____

Employer _____ Office Phone _____ Occupation _____

Address _____ City _____ State ____ Zip _____

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier _____ Phone _____

Policy No. _____ Group No. _____

Address _____

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Secondary Insurance Carrier _____ Phone _____
Policy No. _____ Address _____

IF YOU ARE COVERED UNDER ANOTHER PERSON'S INSURANCE, PLEASE COMPLETE:

Name of Insured _____ Date of Birth _____ SS# _____

Address _____ City _____ State ___ Zip _____
Date _____Patient Name _____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

Allergies to medications? ( )Yes ( ) No, Please list: _____

List all medications you are currently taking: _____ _____ _____
_____ _____ _____ _____ _____

Current **personal** illnesses: ( ) diabetes ( ) heart disease ( ) high blood pressure ( ) elevated cholesterol
( ) asthma ( ) thyroid disease ( ) ulcers ( ) peripheral vascular disease ( ) cancer
Other _____

List any **personal** past illnesses and/or surgeries performed and when they occurred: _____
_____

List all serious illnesses in your immediate **family**:_____

Do you smoke? ( )Yes ( )No If yes, how much? _____ Do you drink? ( )Yes ( )No If yes, how much?_____

Do you exercise regularly? ( )Yes ( )No If yes, how much? _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Chief Complaint (reason for visit): _____

Body Part: ( ) Right ( ) Left
( ) Ankle ( ) Foot ( ) Other _____

Date problem started? _____

Briefly describe **how** the injury or problem occurred: _____

Circle the number that best describes your **pain level**: (least severe) 1 2 3 4 5 6 7 8 9 10 (most severe).

Cause of injury: ( ) Car Accident Date_____ ( ) Work Injury Date _____
( ) Personal Injury Date _____ ( ) None

How long does the pain last? _____ Was there a prior injury to this body part? _____

Is the pain? ( ) Dull ( ) Sharp ( ) Shooting You are: ( ) Right-handed ( ) Left-handed

What treatments have you received (i.e., ice, elevation, medication, therapy)?_____
_____

Does the problem interfere with normal activities? Please explain: _____

If applicable, How far can you walk with no or minimal pain?_____

Do you use any support (i.e., brace, cane, walker, other)? _____

REVIEW OF SYSTEMS

Have you had any problems related to the following systems in the past year? Circle Y for Yes or N for No.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Other _____		

Neurologic

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
Other _____		

Dermatologic

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus Problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary Frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychiatric

Anxiety	Y	N
Depression	Y	N
Other _____		

Physician Signature _____ Date _____

Date _____ Patient Name _____

CONSENT INFORMATION

CONSENT TO TREAT

This information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Teaneck Podiatry, LLC, to administer such procedures and treatment as they deem necessary. They have implied no guarantee of cure.

Patient Initials _____ Date _____

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Teaneck Podiatry,LLC to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Parent/Guardian Initials _____ Date _____

FOR WOMEN ONLY

The doctor or a staff member of Teaneck Podiatry,LLC, has advised me that x-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patient Initials _____ Date _____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster, or attorney involved in this case.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Teaneck Podiatry,LLC
470 Queen Anne Road
Teaneck, NJ 07666

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of Teaneck Podiatry,LLC's HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information _____

_____

Signature _____ Date _____

RESPONSIBILITY OF PAYMENT FOR ORTHOTICS

I understand that Dr. Margolin may prescribe Orthotics as a component of my care. I further understand and acknowledge that my health insurance plan is an arrangement between my respective carrier and myself and that payment for Orthotics may not be a covered benefit under my plan. Although Teaneck Podiatry, LLC will make every effort to collect payment from my insurance carrier, I understand that payment is ultimately my responsibility.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges related to the prescribed Orthotics. However, I acknowledge and agree to make payment in full in the event that the charges associated with the prescribed Orthotics are not covered or paid by my respective insurance plan.

RESPONSIBILITY OF PAYMENT FOR ROUTINE FOOT CARE

I understand that my insurance plan may not cover routine foot care unless medically indicated. Although Teaneck Podiatry, LLC will make every effort to collect payment from my insurance carrier, I understand that payment is ultimately my responsibility. I acknowledge and agree to make payment in full in the event that the charges associated with the provision of care are not covered or paid by my respective insurance plan.

Patient's Signature _____Date _____