Community Foot and Ankle of Mentor

Patient Registration and History

Name:_____DOB: _____Age: _____Height:_____Weight:_____

Blood Pressure_____Primary Care Physician_____Last Seen_____

Shoe Size ____Dominant Hand R or L _____Primary Language_____

Please complete all the sections below:

MEDICAL HISTORY

Do you currently have or have a history of any of the following? Please check all that apply:

Skin

__Bleeding Tendency

_Bruise easily

_Eczema

_Psoriasis

Lung

__Asthma

_Bronchitis

_Emphysema

_Pneumonia

_Shortness of breath

_COPD

Skeletal

__Osteoporosis

_Osteopenia

_Arthritis

_Rheumatoid Arthritis

_Frequent fractures

_Gout

Head

_Migraines

_Dizziness

_Cataracts

_Macular Degeneration

_Glasses/Contacts

_Hearing Loss

_Frequent nose bleeds

_Dentures

_Thyroid Problem

_Seizure

_Dementia

Gallbladder/Liver/Kidney

_Hepatitis

_Gall Stone

_Kidney Stone

_Jaunice

_Dialysis

_Blood in urine

_Incontinence

_Cirrhosis

Other

_Diabetes

*year diagnosed ___

*last blood sugar

*Last hemoglobin A1C ___

*Insulin Dependent__

Heart	Stomach	Autoimmune Disorder
_Stroke/TIA	_Loss of appetite	*HIV _
_Heart Attack	_Ulcers	*AIDS _
_Arrhythmia	_Acid Reflux	*Lupus _
_Murmur	_Eating Disorder	*MS _
_Pacemaker		*Other _
_High Blood Pressure		
_Raynaud		_Congenital Abnormalities
_Circulatory Problems		* Type ___
_Varicose Veins		
_Blood Clot		_Mental Disorder
_Anemia		*Type ____
_Coronary Artery Disease		
_High Cholesterol		_ # of pregnancies

Please list any recent Hospitalizations: _____

_____

_____

_____

Please list all surgeries and surgical dates: _____

_____

_____

_____

SOCIAL HOSTORY

Living Arrangements

Who lives in your household? _____

Smoking:	Alcohol Use:	Illegal drug use:
Current __ __packs per day X__ years	# of alcoholic drinks per week_	Drug_____
Former__ __packs per day X __years		
Never __		

Reason for today's visit: _____

_____

_____

Duration of Problem: _____

Have you been treated for this problem in the past? _____ If yes, by whom? _____

On a scale of 1 to 10, (1 being little to no pain, 10 being extreme pain) ___

Please note any of the symptoms you may be experiencing? Check all that apply:

_Swelling _Numbness _Sharpness _Grinding

_Burning _Tingling _Stabbing _Grating

What worsens your symptoms/pain? _____

What relieves your symptoms/pain? _____

MARK THE AREA (S) BELOW TO IDENTIFY ANY PROBLEMS YOU MAY BE HAVING

Please list all prescription and over the counter medications/supplements:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies you may have:

Allergies	Reaction
_____	_____
_____	_____
_____	_____

Community Foot and Ankle of Mentor

7230 Mentor Ave.

Mentor Ohio 44060

(440)946-5858

X RAY AUTHORIZATION

I hereby request and authorize, Community Foot and Ankle of Mentor, to take x rays of my feet/foot for the purpose of diagnostic evaluation.

It is my complete understanding that for insurance verification purposes, Community Foot and Ankle of Mentor must retain these x rays as a part of my permanent file.

Should I desire a set of these x rays for any reason, I understand that any fees resulting from this service are solely my responsibility.

There isn't at this time, any possibility that I could be or am pregnant.

_____

Signature-(patient or authorized)

_____

Date

_____

Witness

Rev. 6/2016

PATIENT RECORDS OF DISCLOSURES

In general, the HIPA privacy rule gives individuals the right to request, uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of (PHI) be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home

Do you give Community Foot and Ankle of Mentor permission to call your home and leave a message about your next appointment?

__YES __NO If no, what # would you like to be contacted at? _____

Home telephone # _____

__OK to leave a detailed message

__Leave call back number **Only**

Cell Phone# _____

__Ok to leave a detailed message

__Leave call back number **Only**

Work Telephone # _____

__ OK to leave a detailed message

__ Leave call back message **Only**

__Mail to my home address

__ Mail to another address (Please specify)

E-Mail: _____

Is there a relative or friend that you would like to have permission for our office to speak with in regards to your medical conditions or billing questions? If a person is not listed on this form and calls our office to discuss matters relating to your medical condition or billing we will not discuss this information with them.

I give permission for _____ to speak with Dr. Robert J. Rosenstein, Medical Director, associate, or a representative of Community Foot and Ankle of Mentor, Inc. in reference to my medical information.

_____ _____

Patient Signature Date

_____ _____

Print Name Birthday

If this form is being completed by someone other than the patient:

_____ _____

Name Relationship to Patient

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. We participate with most insurance plans. We will file an insurance claim on your behalf. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

2. It is the patient's responsibility to pay any co-payments at the time of service. This arrangement is party of your contract with your insurance company. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment or financial arrangements are due at the time of the visit.

3. In the event that your insurance plan determines a service to be "not covered". You will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

4. Payment for professional services can be made with cash, check, or major credit card companies and care credit.

5. It is the patient's responsibility to provide us with insurance information and bring their insurance card when a change occurs.

6. It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice before that visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.

7. Our policy is to charge $50.00 for no-show appointments. If you fail to cancel an appointment within 24 hours, you will be charged for an office visit. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

8. A charge of $35.00 will be added to your account for any returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the practice's financial policy and agree to abide by its guidelines. I understand any past due balances can be placed for collections with any third party agency. Any additional charges incurred to collect the balance due such as court costs and/or attorney fees will be added to the unpaid balance due.

X_____

Signature of patient (or responsible party, of minor) Date