NEW PATIENT REGISTRATION FORM

Welcome! Please fill out this form completely using your **FULL LEGAL NAME**.
Information provided must match your insurance card or we will be unable to file your medical claim.

DATE: ______________________

PATIENT NAME *(including middle initial)*	❑ Male ❑ Female	DATE OF BIRTH	AGE	MARITAL STATUS: ❑ S ❑ M ❑ D ❑ W

STREET ADDRESS	APT#	CITY, STATE	ZIP + 4 DIGITS	SSN #

HOME PHONE	CELL PHONE	EMAIL ADDRESS

PREFERRED METHOD OF CONTACT

❑ Home Phone ❑ Cell Phone ❑ Text ❑ Email

I AUTHORIZE SMS/text messages to the cell number provided above ❑Yes ❑No

I AUTHORIZE email correspondence to email provided above ❑Yes ❑No

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY, STATE	ZIP

SPOUSE'S NAME	DATE OF BIRTH	SSN #

SPOUSE'S EMPLOYER	EMPLOYER'S ADDRESS	WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE? *(Please share name of referring Physician, Clinic or Patient)*

❑ PHYSICIAN ______________________ ❑ PATIENT ______________________ ❑ DRIVE-BY ❑ INSURANCE ❑ INTERNET

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?	PHONE NO

GUARANTOR INFORMATION

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR/NOT RESPONSIBLE FOR PAYMENT

GUARANTOR NAME	❑ Male ❑ Female	DATE OF BIRTH	SSN#

GUARANTOR'S ADDRESS	PHONE NO

RELATIONSHIP TO PATIENT *(please specify)*

INSURANCE INFORMATION

PLEASE PROVIDE CURRENT INSURANCE CARD(S) & PHOTO ID TO FRONT DESK FOR SCANNING

PRIMARY INSURANCE	POLICY ID#	GROUP #

SUBSCRIBER NAME	❑ Male ❑ Female	DATE OF BIRTH	RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other

SUBSCRIBER ADDRESS *(if different from the patient)*	PHONE NO

SUBSCRIBER EMPLOYER	SSN #

SECONDARY INSURANCE	POLICY ID#	GROUP #

SUBSCRIBER NAME	❑ Male ❑ Female	DATE OF BIRTH	RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other

SUBSCRIBER ADDRESS *(if different from the patient)*	PHONE NO

SUBSCRIBER EMPLOYER	SSN #

PLEASE TURN PAGE & COMPLETE BACK SIDE ➔

PATIENT NAME: ____ **DOB:** _____________

*Please **sign and date** the bottom of this form indicating you have read and understand each policy. If you have any questions regarding a policy or your insurance coverage, please do not hesitate to ask.*
We are here to help!

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) am eligible for the insurance coverage as indicated on this form and assign directly to Madison Foot Clinic, PLLC (Mohammad R. Parsa, DPM). all medical and surgical benefits, including major medical benefits to which I am entitled by my insurance carrier(s) be made directly payable to them for medical services rendered. I authorize the use of this signature on all insurance submissions. I authorize release of all information necessary to process claims for services I have been provided. I acknowledge that this assignment of benefits does not relieve me of my financial responsibility for medical fees/charges incurred by me or anyone on my behalf regardless of insurance coverage/payment. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES

I have read and understand the financial policies. I understand am legally responsible for the payment of all for all services rendered to me by Madison Foot Clinic, PLLC regardless of insurance coverage. I understand account balances after insurance must be paid within 120 days of patient billing (unless prior payment arrangements have been made) to avoid collection agency action. I understand that in the event my account is turned over to a collection agency, a 33.33% fee added will be added to the account balance.

I understand it is my responsibility to provide Madison Foot Clinic with timely information about changes to my insurance coverage, and respond promptly to requests for information as they occur. I understand that failure to do so may result in my claim being denied and no appeal rights afforded me.

RECEIPT OF HIPAA PRIVACY POLICIES

I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or have had the opportunity to read if I so chose) and understand how my protected health information (PHI) may be released according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and agree to its terms.

RELEASE OF INFORMATION

You may designate individuals (spouse, family, caregiver, friend) to have access to your Protected Health Information (PHI). Please list any specific individuals whom you authorize Madison Foot Clinic to release information to regarding your healthcare. This release will remain in effect until you revoke it, in writing which you may do at any time.

❑ Check here if you **DO NOT** want anyone other than yourself to have access to your PHI

NAME: ______________________ Contact Info: ______________ Relationship: ____________

NAME: ______________________ Contact Info: ______________ Relationship: ____________

NAME: ______________________ Contact Info: ______________ Relationship: ____________

PHOTO CONSENT

I give consent for medical photographs to be taken in connection with the services received from Madison Foot Clinic, PLLC. I understand these photos will be used in my medical record, and if strictly in the judgment of Dr. Parsa, for purposes of medical teaching, research or for publication in medical journals. I understand that if photos are used for demonstration purposes including office photo albums, clinic website, or professional medical journals I will not be identified by name, nor compensated. Refusal to consent to photographs will in no way affect the medical care I receive.

Signature of Patient/Guarantor: ____________________________________ Date: ____________

Patient NAME: ______________________ **DOB:** ______________ **Date:** ________

REASON FOR TODAY'S VISIT (Please list your **PRIMARY CHIEF COMPLAINT**): ______________________

____

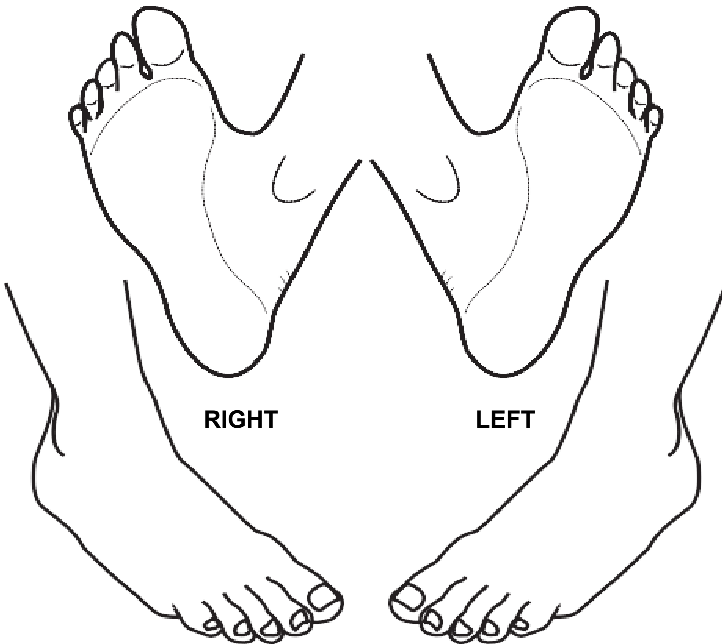
Is the problem due to any injury? ❑YES ❑NO If yes, describe nature or accident/injury: ______________________

____ **DATE OF** injury/accident: __________

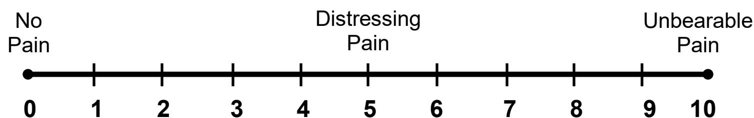
Is this a **WORK RELATED** injury? ❑YES ❑ NO Have you received previous treatment? If yes, describe treatment: ________

____

Please mark the **LOCATION** of your pain/problem:



PAIN SEVERITY: Circle the number that best that describes your pain:



HOW LONG have you had this problem?

________ Days ________ Weeks

________ Months ________ Years

Has pain gotten: ❑ Better ❑ Worse ❑ Same

ONSET: ❑ Slow ❑ Sudden ❑ Traumatic

TYPE of pain: ❑ Sharp ❑ Stabbing ❑ Ache/Deep ❑ Burning ❑ Pins/Needles ❑ Radiating ❑ Throbbing

WHEN do you feel pain?

❑ First steps after rest ❑ Work ❑ Activity ❑ Evening ❑ Night

What **WORSENS** your condition?

❑ Walking ❑ Running ❑ Standing ❑ Shoes ❑ Activities ❑ Rest

Other: ______________________

____

What **IMPROVES** your condition? ______________

____

____

TOBACCO: ❑ Never ❑ Quit ❑ Yes - ❑ ½ PPD ❑ 1 PPD ❑ > 1 PPD #Years Smoked: __________

ALCOHOL: ❑ Never ❑ Social ❑ Moderate ❑ Daily ❑ Heavy Recreational Drugs? ❑ Yes ❑ No

EXERCISE: ❑ Never ❑ Rare ❑ Occasional ❑ Weekly ❑ Several times a week ❑ Daily

Type of exercise/athletic activity: ______________________________

MEDICATIONS: (List all current Rx, OTC Meds and Vitamins)

____

____

____

____

ALLERGIES: ❑ None/No know allergies

❑ Aspirin ❑ Codeine ❑ Iodine ❑ Epinephrine

❑ Penicillin ❑ Sulfa ❑ Latex

❑ Adhesive tape ❑ Demerol ❑ Sedatives

❑ Lidocaine/Anesthetics ❑ Other: __________

Do you take BLOOD THINNERS? ❑ Yes ❑ No

FEMALE PATIENTS ONLY: Are you pregnant? ❑ YES ❑ NO Do you take oral contraceptives? ❑YES ❑NO

PREFERRED PHARMACY: ______________________ **Phone Number:** ______________________

Patient NAME: ________________________________ **DOB:** ____________________ **Date:** ____________

PRIMARY CARE Physician: ____ Date last seen: ____________________

SURGICAL HISTORY: Please list all prior surgeries and dates performed ____

____

____

HEALTH HISTORY: Do you have now, or have you ever had any of the following health problems?

❑ **AIDS/HIV**	❑ **Bleeding** Disorder	❑ Nervous Problems/Anxiety
❑ **ASTHMA**	❑ **EPILEPSY**	❑ **Peripheral Vascular Disease**
❑ Arthritis	❑ **FAINTING**	❑ Gout
❑ Acid Reflux; GERD	❑ High Blood Pressure	❑ Heart Problems/Murmur
❑ Heart Attack	❑ Stroke/Paralysis	❑ **RHEUMATIC FEVER**
❑ Phlebitis/Blood Clots/DVT	❑ **KIDNEY** Disease	❑ Stomach Trouble/Ulcers
❑ **LIVER** Disease	❑ Emphysema/COPD	❑ CANCER
❑ **Hepatitis**	❑ Stomach Ulcers	❑ Thyroid Disease
❑ Tuberculosis	❑ **CIRCULATORY** Problems	❑ **DIABETES****

**** What type of Diabetes do you have?** ❑ Type I ❑ Type II ❑ Gestational **Insulin dependent?** ❑ Yes ❑ No

How often do you check your blood sugar levels? ____
Current glucose/blood sugar level? ____

FAMILY HISTORY: Please indicate any **FAMILY** history of the following chronic conditions along with relationship of family member.

❑ Diabetes	____________________	❑ Cancer	____________________
❑ Hypertension	____________________	❑ Bleeding Disorders	____________________
❑ Heart Disease	____________________	❑ Rheumatology	____________________
❑ Kidney Disease	____________________	❑ Stroke	____________________
❑ OTHER	____		

REVIEW OF SYSTEMS **Please indicate if you have had any of the following symptoms:**

Problems with eyes or ears	❑ Yes	❑ No	Weight Change in the last year	❑ Yes	❑ No
Swollen Glands/Unusual lumps	❑ Yes	❑ No	Racing heart/Skipping beats	❑ Yes	❑ No
Chest Pain/Tightness	❑ Yes	❑ No	Stomach/Abdominal pains	❑ Yes	❑ No
Frequent nausea/Vomiting	❑ Yes	❑ No	Shortness of breath	❑ Yes	❑ No
Ankle/Leg swelling	❑ Yes	❑ No	Frequent constipation/Diarrhea	❑ Yes	❑ No
Frequent urination	❑ Yes	❑ No	Fatigue/Tiredness	❑ Yes	❑ No
Cholesterol problems	❑ Yes	❑ No	Excessive thirst	❑ Yes	❑ No
Frequent headaches	❑ Yes	❑ No	Numbness/Tingling	❑ Yes	❑ No
Back pain	❑ Yes	❑ No	Frequent cough/Wheezing	❑ Yes	❑ No
Joint pain/Swelling	❑ Yes	❑ No	Fractured or broken bones	❑ Yes	❑ No
Skin problems/Rash	❑ Yes	❑ No	HIV/AIDS concerns	❑ Yes	❑ No

LANGUAGE: ❑ English ❑ Other ________________ **ETHNICITY:** ❑ Hispanic/Latino ❑ Non Hispanic/Latino ❑ DECLINE

RACE: ❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Native Hawaiian/Pacific Islander ❑White ❑ DECLINE

HEIGHT: ______________ **WEIGHT:** ______________ **SHOE SIZE:** ______________

I certify the information provided by me is accurate and true to the best of my knowledge. I hereby give consent to Dr. Parsa to examine and administer treatment as may be deemed necessary by him in the diagnosis and/treatment of my foot condition.

____ ________________________

Signature of Patient Date