CAPITAL FOOT AND ANKLE
PATIENT REGISTRATION FORM

This information is confidential

PATIENT INFORMATION

Name_____

Address_____

City_____

State_____ Zip_____

Home Phone (____)_____

Work Phone (____)_____Ext_____

Cell Phone (____)_____

Date of Birth_____

E-mail:_____

Primary Physician_____

Phone# _____

Referring Physician_____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian

☐ Hispanic Latino ☐ Veteran ☐ Other

Occupation _____

Employer _____

Address _____

_____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse ☐ Other_____

PHARMACY INFORMATION

Pharmacy Name_____

Phone#: _____Fax#:_____

Address_____

City_____ State_____

EMERGENCY CONTACT (If other than Spouse)

Name_____

Relationship:_____

Telephone (____)_____

Guarantor Information: Complete if different from Patient

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____)_____

DOB_____

Employer_____

Address_____

Work Phone(____)_____Ext_____

CAPITAL FOOT AND ANKLE
PATIENT REGISTRATION FORM

Is your treatment today due to:

……..a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated ☐ Yes ☐ No

……..a motor vehicle accident ☐ Yes ☐ No Accident Date_____

……..a an accident/ liability case ☐ Yes ☐ No Accident Date_____

I hereby authorize Carla Docharty DPM, Alton Smalley DPM, Jamie Bakal DPM and Mark J. Drake DPM, to perform an examination and or any medical treatment deemed necessary by the treating physicians. This includes, but is not limited to any required medical examinations, x-rays, medical procedures and medical diagnostics or laboratory tests ordered by or performed by the treating physician(s).

Signature X_____ Date_____

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X_____ Date_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Capital Foot & Ankle** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<table>
<tr><th colspan="2">PATIENT'S NAME (Please Print)</th><th>PROVIDER: Name, Address, and Zip</th></tr>
<tr><td colspan="2"></td><td rowspan="4">Capital Foot & Ankle
3800 J Street
Sacramento, CA 95816</td></tr>
<tr><td colspan="2">PATIENT'S SIGNATURE</td></tr>
<tr><td>PATIENT'S MEDICARE NO.</td><td>DATE</td></tr>
<tr><td></td><td></td></tr>
</table>

Patient Name: _____ **Date:** _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **When did pain/discomfort begin (date):** _____

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ Yes ☐ No _____

5. **Have you had an accident?** ☐ Yes ☐ No _____

6. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Prostate Disorders
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High blood pressure	☐ Osteoarthritis	☐ Other: _____

7. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

8. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____	☐ Aspirin _____	☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____	☐ Shellfish _____	☐ Sulfa Drugs _____
☐ Nickel / Metal _____	☐ Radiographic Contrast Dye _____	
☐ Other _____		

9. **Are you currently pregnant?** ☐ Yes ☐ No _____

10. **What is your shoe size?** _____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

    Surgery / Date: _____

_____

12. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use	☐ Alcohol Use	☐ Exercise habits_____
☐ Caffeine Use	☐ Drug use (recreational, IV)	

13. **Job:** _____ **Job requirements: %** Sitting _____ **%**Standing _____ **%**Lifting _____

14. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes_____	☐ Heart Disease _____	☐ Kidney Disease _____
☐ Hypertension _____	☐ Stroke _____	☐ Mental Illness _____
☐ Rheumatology _____	☐ Bleeding Disorders _____	☐ Cancer _____

☐ Other family History: _____

15. **Height:** _____ **Weight:** _____

For office use: B/P _____ Pulse _____ Resp. _____ Temp. _____

Patient Name: _____ **Date:** _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
☐ Ear Drainage	☐ Jaw Pain		
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions Infections	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Hair Loss	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth		
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Lesions Infections	☐ Sun Sensitivity

Capital Foot & Ankle Capital Foot & Ankle
3800 J Street, Suite 200
Sacramento, CA 95816

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (Hipaa), I have certain rights to privacy regarding my protected health information I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

Capital Foot & Ankle

3800 J Street, Suite 200 Sacramento, CA 95816	5 Medical Plaza Drive, Suite 110 Roseville, CA 95661

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I Understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____