# PODIATRIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**INSURANCE ASSIGNMENT AND RELEASE**

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**MEDICARE/MEDIGAP AUTHORIZATION**

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

## 3 PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

## 4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?
☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

| | | |
|---|---|---|
| Ankle Pain | ☐ Yes | ☐ No |
| Athlete's Foot | ☐ Yes | ☐ No |
| Bunions | ☐ Yes | ☐ No |
| Corns and Calluses | ☐ Yes | ☐ No |
| Cramps or Numbness in Feet or Legs | ☐ Yes | ☐ No |
| Flat Feet | ☐ Yes | ☐ No |
| Foot or Leg Cramps | ☐ Yes | ☐ No |
| Heel Pain | ☐ Yes | ☐ No |
| Ingrown Toenails | ☐ Yes | ☐ No |
| Plantar Warts | ☐ Yes | ☐ No |
| Swelling in Ankles or Feet | ☐ Yes | ☐ No |
| Tired Feet | ☐ Yes | ☐ No |

## 5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| Allergies to Anesthetics | ☐ Yes | ☐ No | Eye Problems | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Allergies to Medicine or Drugs | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Foot or Leg Cramps | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Artificial Heart Valves or Joints | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Swelling in Ankles, Feet | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Hepatitis or Jaundice | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Tired Feet | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Neuropathy | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss, unexplained | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| Ear Problems | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No | | | |

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

## 6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

## 7 ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

## TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

ALABAMA MEDICAL & SURGICAL FOOT CENTER KEVIN L. WALDROP, DPM 1960 GADSDEN HWY STE 120, BIRMINGHAM, AL. 35235 (205) 655-1114

**ATTN: HOSPICE PATIENTS**

**PLEASE NOTIFY OUR OFFICE IF YOU ARE ENROLLED IN HOSPICE.**

**ATTN: MEDICARE PATIENTS**

**MEDICARE DOES NOT USUALLY PAY FOR ROUTINE FOOT CARE WICH INCLUDES TRIMMING OF CORNS OR CALLUSES AND TRIMMING OF FUNGAL OR THICK TOENAILS. ONLY IF YOU ARE DIAGNOSED AS A DIABETIC DOES MEDICARE PAY FOR TOENAILS TO BE TRIMMED.**

**NON COVERED SUPPLIES**

**AS YOUR PHYSICIAN, THERE MAY BE A CERTAIN SERVICE OR SUPPLIES I FEEL ARE NECESSARY FOR MATENANCE OF GOOD HEALTH THAT ARE NOT COVERED BY YOUR INSURANCE. FOR EXAMPLE, ORTHOPEDIC SUPPLIES (AIRCAST, BRACES, HEEL CUPS, ORTHOTICS, SURGICAL SHOES AND BOOTS) MAY NOT BE COVERED BY YOUR CONTRACT. WE WILL ONLY ORDER ITEMS WE FEEL ARE NECESSSARY FOR YOR TREATMENT AND CARE. IF YOU HAVE ANY QUESTIONS ABOUT COVERAGE, SOMEONE IN OUR OFFICE WILL BE HAPPY TO ANSWER YOUR QUESTIONS.**

**INSURANCE BENEFITS**

**OUR OFFICE MAKES EVERY ATTEMPT TO VERIFY YOUR INSURANCE BENEFITS AND FILE YOUR INSURANCE. HOWEVER, IT IS THE PATIENTS' RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN BENEFITS. THE INFORMATION WE OBTAIN FROM YOUR INSURANCE IS NOT A GUARANTEE OF PAYMENT AND IS SUBJECT TO CHANGE PER YOUR INSURANCE COMPANY.**

**NO SHOW / CANCELLATION FEE**

**PLEASE BE AWARE YOU MAY BE CHARGED A $25 NO SHOW FEE. IF YOU NEED TO CANCEL OR RESCHEDULE AN APPOINTMENT PLEASE GIVE 24HR NOTICE.**

**SERVICES THAT MAY NOT BE COVERED WERE EXPLAINED TO ME. I HAVE READ THE POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY CONTRACT, AS INDICATED BY MY SIGNATURE.**

**SIGNATURE : PATIENT OR GUARDIAN:_____**
**DATE:_____**

**Alabama Medical and Surgical Foot Center P.C.**

**Kevin L. Waldrop DPM**

**1960 Gadsden Highway 11 Suite # 120**

**Birmingham, Al 35235**

I acknowledge that I was provided a copy of the notice of Privacy Practices.

I understand that I may contact this office for further information and clarification.

If deemed necessary HIPAA allows this office to share you medical information with members of your family. Please list any family member of your immediate family that you **DO NOT** wish to have access to your protected medical information.

_____

_____

Medical information can be disseminated by: (check all that apply)

____ Telephone patient only

____ Telephone to spouse

____ Message on answering machine

____ Other _____

_____ _____

Patient signature Date

_____

Parent or Authorized Representative (if applicable)