

# PATIENT REGISTRATION

Date \_\_\_\_\_

## WELCOME TO OUR OFFICE

### PATIENT INFORMATION

SS# \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last First Middle

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M F

E-mail Address \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation/Position \_\_\_\_\_

Business Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation/Position \_\_\_\_\_

Business Phone \_\_\_\_\_

### PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT (Please complete if other than patient)

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation/Position \_\_\_\_\_

Business Phone \_\_\_\_\_

### INSURANCE INFORMATION

Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

#### Secondary Insurance

Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ SS # \_\_\_\_\_

Have you ever been treated by a podiatrist? \_\_\_\_\_ Dr. \_\_\_\_\_

In case of emergency, whom should be notified \_\_\_\_\_ Phone \_\_\_\_\_

Name & address of nearest relative \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**PLEASE COMPLETE MEDICAL HISTORY**

**MEDICAL HISTORY** (Please check the appropriate boxes)

General Health \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

I have, have had, or possess a family history of the following:

	Yes	No	Family History		Yes	No	Family History
Anemia	___	___	___	Cardiovascular (Heart Disease)	___	___	___
Arthritis	___	___	___	Respiratory (Breathing Problems)	___	___	___
Bleeding Disorders	___	___	___	Gastrointestinal (Stomach Distress)	___	___	___
Diabetes	___	___	___	Urinary Problems (Kidney Disease)	___	___	___
Gout	___	___	___	Please Specify _____			
Hypertension	___	___	___	_____			
Stroke	___	___	___	_____			
Foot Problems	___	___	___	_____			
Have you ever been HIV tested?	___	Yes ___	No ___	If yes, what were the results _____			
Women: Are you pregnant?	_____			_____			
What medications are you taking	_____			Medication allergies _____			
	_____			_____			
	_____			Other allergies _____			
	_____			_____			

Are there any other medical conditions we should be aware of? (Specify) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Family Pharmacy \_\_\_\_\_

Briefly describe your foot problem \_\_\_\_\_

I hereby request and give permission to Dr. Alan K. Mauser and whomever he may designate as his assistants, to administer treatment, and to perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my foot complaints.

AUTHORIZATION: I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances. I understand that interest will be applied to all accounts 60 days or more past due at a rate of 1 ½% per month, annual rate of 18% and hereby agree to pay such charges. I understand that there will be a \$20.00 fee applied to all returned checks.

I further authorize the release of any medical information to other doctors treating me.

I further authorize payment of Medicare and/or other insurance benefits to Dr. Alan K. Mauser for the services he performs.

I understand that payment for services at the time they are rendered is expected, unless specific and special arrangements are made prior to the appointment.

A photostatic copy of these authorizations shall be as effective and valid as the original and shall remain in effect for one year following my last treatment.

Name (print) \_\_\_\_\_ Relationship (to Patient) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Acknowledgement of Receipt Of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

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Patient Name (Please Print)

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Date

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Parent or Authorized Representative (if applicable)

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Signature