Elevatefootankle.com

2880 Plymouth Avenue
Rocky River, Ohio 44116
(440) 333-5888

4338 Mayfield Road
South Euclid, Ohio 44121
(216) 381-3600

Patient Registration Form

Demographics

Patient's First Name: ______________________________________M.I.________ Last Name:_______________________________________

Date of Birth:__________________________ Sex: ❑Male ❑Female Social Security Number:_________________________________

Address:____ City/State/Zip:_____________________________________

Cell Phone:___________________________ Home Phone:________________________ Email:___________________________________

Preferred Method of Contact: ❑Cell Phone ❑Home Phone ❑Email

Emergency Contact: ____________________________Relationship: _____________________Phone #_____________________________

Do we have your permission to speak with this person regarding your medical condition if we cannot reach you? ❑Yes ❑No

How did you hear about us?____

Preferred Pharmacy Name & Address:____

Guarantor Information: ❑ Check if same as patient (above)

Name:____ Relationship to Patient:_______________________________

Address:____City/State/Zip:_____________________________________

I acknowledge full financial responsibility for any services rendered and I understand that Elevate Foot and Ankle will send my claims to my insurance company for payment. I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance or any payment that is applied to my deductible, co-insurance or copayment remain my responsibility and I request payment of insurance benefit to this office. I authorize the release of any medical information necessary to process any claims and I understand that I am responsible for any referrals that are required by my insurance. I also understand that I may incur a $25 fee if I miss my appointment without giving at least 24-hour notice.

X: ____ Date: __________________________________

Patient/Guarantor Signature

Consent for Treatment:

I consent to examination and treatment by Elevate Foot and Ankle by the attending physician and any of their associates/assistants. I certify that no guarantees have been made as to the results obtained by services received at Elevate Foot and Ankle. I understand that I may be photographed for documentation purposes.

X: ____ Date:__________________________________

Patient/Guardian Signature

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 *"HIPPA"), 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 healthcare 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 certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. 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.

Name: ____ Relationship to Patient (if applicable):________________________________

Signature:____ **Date:** ______________________________________

Office Use Only: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below
Date:______________________**Initials**_______**Reason:**____

Medical History

Podiatric History

Reason for today's visit:

____

____

Duration of problem: ______________________________ Have you had prior treatment for this issue?________________________________

Is this related to an injury? ❑Yes ❑No If yes, what was the date of your injury:____

Shoe Size:____________ Primary Care Physician: __________________________________ Date of last visit:_________________________

Medical History

Do you have or have ever been treated for the following: (Check all that apply)

❑Acid Reflux ❑Anemia ❑Anxiety ❑Arthritis ❑Asthma ❑Back Problems ❑Bleeding Problems ❑Bronchitis ❑Cancer (type__________)
❑Diabetes (type________) ❑Depression ❑Emphysema/COPD ❑Epilepsy ❑Eye Problems ❑Gout ❑Headache/Migraine ❑Heart Attack
❑Hepatitis ❑High Blood Pressure ❑High Cholesterol ❑HIV/AIDS ❑IBS ❑Kidney Disease ❑Neuropathy ❑Osteoporosis ❑Pacemaker
❑Rheumatoid Arthritis ❑Sciatica ❑Sinus Problems ❑Spinal/ Disc Problems ❑Stomach Ulcer ❑Stroke ❑Vascular Disease
❑None of these
❑Other____

Social History

What is your occupation? _______________________________

What is your marital status? ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑I'd rather not say

Do you use tobacco? ❑Yes ❑No Packs per day__________ Have you used tobacco in the past? ❑Yes ❑No Packs per day_________

Do you drink alcohol? ❑No ❑Rarely ❑Occasionally ❑Socially ❑Daily

Surgical History

List all prior surgeries and dates:

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Family Medical History

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Allergies

Are you allergic to any of the following: (Check all that apply)

❑No Known Allergies ❑Aspirin ❑Codeine ❑Cortisone ❑Latex ❑Local Anesthetics ❑Penicillin ❑Sulfa

❑Other____

Medications

Please include dosage and frequency

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