KADIN
Foot & Ankle Center

(Please Print)

# REGISTRATION FORM

Today's Date _____/_____/_____

## PATIENT INFORMATION

| Patient's Last Name | First | Middle | ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss | ☐ Sr. ☐ Jr. |
|---|---|---|---|---|

| Street Address | City | State | Zip Code |
|---|---|---|---|

| Home Phone # | Cell Phone # | Work Phone # | E-mail Address |
|---|---|---|---|

| Patient's Birth Date | Age | Social Security Number | **Marital Status** ☐Single ☐Mar ☐Widow ☐Div | **Sex** ☐ M ☐ F |
|---|---|---|---|---|

| Parent or Guardian (if patient is under 18 years of age): | Relationship to Patient: |
|---|---|

## INSURANCE INFORMATION

| **Primary Insurance** | Policy Holder | Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other | **Policy Holder's Birth Date** |
|---|---|---|---|
| Policy Holder's Employer | Policy Holder's Employer Address | | |
| **Secondary Insurance** | Policy Holder | Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other | **Policy Holder's Birth Date** |

**Check Here ☐ if:** **Today's visit is related to an auto accident or worker's compensation. Please ask for additional paperwork.**

## Whom may we thank for referring you?

| | |
|---|---|
| ☐ Doctor - | ☐ Family - |
| ☐ Hospital - | ☐ Friend - |
| ☐ Insurance Plan | ☐ Google/Internet - |
| ☐ Kadin Website ☐ Facebook | ☐ Other: |

| Name of contact in case of an emergency | Relationship | Phone |
|---|---|---|
| Name of nearest relative not living with you | Address | Phone |

Do you have a Living Will? (for patients 18 yrs. & above) ☐ Yes ☐ No

## FAMILY PHYSICIAN INFORMATION (Please fill in as much information as possible)

| Medical Doctors Name | | | **Date Last Seen by Family Physician:** |
|---|---|---|---|
| Street Address | City | State | Phone Number: |

## Please list any specialist currently treating you:

| Specialist: | Specialist: | Specialist: |
|---|---|---|

**Reason for Today's Visit:** ______________________________

**HOW LONG?** MONTHS YEARS

**PATIENT NAME** **BIRTH DATE** / /

| SHOE SIZE | HEIGHT | WEIGHT | BLOOD SUGAR | LAST BLOOD PRESSURE |
|---|---|---|---|---|
| | | | | |

| **DO YOU SMOKE NOW?** | ☐ NO | ☐ YES | # OF PACK(S)/DAY | **DO YOU DRINK?** | ☐ NO ☐ YES |
|---|---|---|---|---|---|
| **HAVE YOU SMOKED IN THE PAST** | ☐ NO | ☐ YES | | DRINKS PER WEEK | |

## ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

☐ No Known Allergies
☐ Penicillin
☐ Sulfa
☐ Tape
☐ Latex
☐ Codeine
☐ Iodine on Skin
☐ Local Anesthetic
☐ Nausea From Anesthetic
☐ Anti-inflammatory Medication
☐ Other ______________________________

## PAST SURGICAL HISTORY

Have you ever been put to sleep for surgery? ☐ Yes ☐ No

Please list any previous surgeries that you have had:

## Family History Has anyone in your FAMILY ever suffered from any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Cancer | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |
| Diabetes | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |
| Heart Disease | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |
| High Blood Pressure | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |
| Thyroid Disorders | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |
| Other: ____________________ | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ None |

## Indicate which of the following YOU have had or have at present. Check Yes or No to each item

| | | | | | |
|---|---|---|---|---|---|
| Arthritis | ☐ Yes | ☐ No | Hepatitis ____ | ☐ Yes | ☐ No |
| **If yes:** Rheumatoid Arthritis | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No |
| Osteoarthritis | ☐ Yes | ☐ No | H.I.V. Positive | ☐ Yes | ☐ No |
| Back or Neck Pain | ☐ Yes | ☐ No | Kidney Trouble | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No |
| Blood Clots or DVT | ☐ Yes | ☐ No | Neurological Disorder | ☐ Yes | ☐ No |
| Breathing Problems (Asthma, Emphysema, etc.) | ☐ Yes | ☐ No | Psoriasis | ☐ Yes | ☐ No |
| Diabetes (Type _____ ) | ☐ Yes | ☐ No | Psychiatric/Psychological Care | ☐ Yes | ☐ No |
| Fibromyalgia | ☐ Yes | ☐ No | Stomach Problem/Reflux/Heartburn | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No | Seizures | ☐ Yes | ☐ No |
| Gout | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Heart Disease/Heart Attack | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No | *Other:* ________________________________________________ | | |

## Indicate which of the following you have had or have at present. Check Past or Current for each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Foot / Leg Injuries | ☐ Past | ☐ Current | Weak Ankles | ☐ Past | ☐ Current | Foot Skin Problems | ☐ Past | ☐ Current |
| Foot / Leg Surgery | ☐ Past | ☐ Current | Bunions | ☐ Past | ☐ Current | Unequal leg Length | ☐ Past | ☐ Current |
| Foot / Leg Cramps | ☐ Past | ☐ Current | Knee Pain | ☐ Past | ☐ Current | Foot / Leg Numbness | ☐ Past | ☐ Current |
| Foot Ulcers | ☐ Past | ☐ Current | Other Foot/Leg Problems: | | | | | |

**Have you had previous treatment by a Podiatrist?** ☐ Yes ☐ No For What?

What previous treatments have you had on your foot/ankle? ☐Surgery ☐Orthotics ☐Oral Medications ☐Cortisone Shots

**PATIENT NAME** **BIRTH DATE** / /

## MEDICATIONS

***PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION & OVER THE COUNTER***

| MEDICATION | DOSAGE |
|---|---|
| I give Kadin Foot and Ankle Center permission to access my medications electronically. | ☐ Yes ☐ No |
| ☐ **Check here if you are not taking any medications** | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy: ☐Costco ☐CVS ☐Rite Aid ☐Target ☐Wal-Mart ☐Walgreens ☐Wegman's ☐ Shoprite

☐ Medco ☐ Other: ________________________________________

| Address or Cross Streets | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Phone Number | ☐ This is a mail order pharmacy |
|---|---|
| | |

The following questions are completely voluntary. We are making a good faith effort to record this information in order to comply with legal requirements

**Race/Ethnic Identification:**

- ☐ **Check here if you wish to not participate**
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ African American(Non-Hispanic or Latino origin)
- ☐ White(Non-Hispanic or Latino origin)
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Other

**Primary Language:**

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

| Patient/Guardian Signature | Date |
|---|---|
| **X** | |

| For Office Use Only: | Date |
|---|---|

HISTORY REVIEWED BY:

# KADIN
Foot & Ankle Center

Patient Name: ______________________________

**FINANCIAL RESPONSIBILITY**
It is your responsibility to provide us with your current insurance card at **every visit** so that we may bill the insurance company in a timely fashion. If a claim is rejected due to an expired policy or due to non-covered services, you will be held responsible for the outstanding balance. Due to the wide variety of insurance plans, even within one insurer, it is impossible for us to know what is covered under your plan. It is your responsibility to know your insurance plan. Any health insurance deductibles, co-payments and/or co-insurance are your responsibility. You must obtain referrals, second opinions, exclusions of 'pre-existing conditions' and/or other requirements or conditions of your insurance coverage. There is also a $50.00 fee for checks returned for insufficient funds.

**MISSED APPOINTMENTS:** We understand that you may not be able to keep all of your scheduled appointments. Please understand that missed appointments have a detrimental impact on our practice, not only financially, but they also affect our ability to serve others in need of medical care.

A **$25 fee** will be charged for all appointments not cancelled at least 24 hours in advance.
You can be seen in the office after any no show fees have been paid.

**FORMS AND MEDICAL RECORDS FEES:** Due to the increasing cost of providing our patients with the highest standards of care, we must impose a charge for records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:
***All Forms and Dictated letters: $5.00 each***
(Other charges will apply for copies of records for personal use.)

**ASSIGNMENT OF BENEFITS/PATIENT RESPONSIBILITY FORM**
The signature below entitles us to release or disclose to any insurance company, governmental agency, managed care organization and any other entity or person who may be required to pay all or part of the costs of your treatment, hospitalization and/or all medical records or other information from our records relating to you identity, diagnosis, prognosis and treatment. The purpose for the disclosure is to enable Kadin Foot & Ankle Center to secure payment of your bill from all companies/entities that may be required to pay on your behalf. Your insurance company has your permission to pay on your account directly to Kadin Foot & Ankle Center for all professional and/or medical expenses. You agree to pay, in a timely manner, any balance of said professional service charges over and above or not covered by your insurance company. A photocopy of this *Agreement* will be considered as effective and valid as the original.

Signature: ______________________________ Date: ___________

Printed Name: ______________________________ Relationship to Policy Holder: _______________

Patient Name: ______________________

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Kadin Foot & Ankle Center, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provided by Kadin Foot & Ankle Center, PC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kadin Foot & Ankle Center, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Lynn Bankert, Office Manager, at 8008 Route 130, Suite 130, Delran, NJ 08075.

With this consent, Kadin Foot & Ankle Center, PC may call your home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Kadin Foot & Ankle Center, PC may mail or e-mail to my house or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder calls and patient statements. I have the right to request that Kadin Foot & Ankle Center, PC restrict how it used or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement.

By signing this form, I am consenting to allow Kadin Foot & Ankle Center, PC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kadin Foot & Ankle Center, PC may decline to provide treatment to me.

Furthermore, I allow my PHI to be discussed with the following persons:

_____ **Primary Care Physician**

_____ **Family Members** (Please list members below)

Name: ___________________________________ Relationship: _________________

Name: ___________________________________ Relationship: _________________

Name: ___________________________________ Relationship: _________________

Name: ___________________________________ Relationship: _________________

_____ **Other:** ___________________________________________________________

Signature of Patient or Legal Guardian: ______________________________________

Date: __________________ Legal Guardian Name, if applicable: ________________________