KADIN
Foot & Ankle Center

(Please Print)

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name	First Name	Middle Initial

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	Sex
			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

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

☐ Check here if today's visit is related to an **AUTO ACCIDENT or WORKER'S COMPENSATION.**

Whom may we thank for referring you?

☐ Doctor -	☐ Family/Friend-
☐ Insurance Plan	☐ Google/Internet

☐ Kadin Website ☐ Facebook ☐ Other _____

Name of contact in case of an emergency	Relationship	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:** ( )

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

Primary Language: _____

Reason for Today's Visit:

_____ **HOW LONG?** MONTHS YEARS

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

What Treatment: ☐ Ulcers ☐ Surgery ☐ Orthotics ☐ Foot/Leg Numbness ☐ Cortisone Shots

Patient Initials: **Birthdate:**

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

☐ No Known Allergies

☐ Sulfa ☐ Penicillin
☐ Tape ☐ Iodine on Skin
☐ Latex ☐ Anesthesia
☐ Codeine ☐ NSAIDs

☐ Other _____

_____

SHOE SIZE	HEIGHT		WEIGHT	BLOOD SUGAR	
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	

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
Other: _____	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None

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

Bleeding Disorders	☐ Past	☐ Current	Kidney Disease	☐ Past	☐ Current
Blood Clots or DVT	☐ Past	☐ Current	Liver Disease	☐ Past	☐ Current
Breathing Problems (Asthma, Emphysema, etc.)	☐ Past	☐ Current	Neurological Disorder	☐ Past	☐ Current
Diabetes (Type ___)	☐ Past	☐ Current	Osteoarthritis	☐ Past	☐ Current
Fibromyalgia	☐ Past	☐ Current	Psoriasis	☐ Past	☐ Current
Glaucoma	☐ Past	☐ Current	Psychiatric/Psychological Care	☐ Past	☐ Current
Gout	☐ Past	☐ Current	Rheumatoid Arthritis	☐ Past	☐ Current
Heart Disease	☐ Past	☐ Current	Stomach Problem/Reflux/Ulcers	☐ Past	☐ Current
Heart Murmur	☐ Past	☐ Current	Seizures	☐ Past	☐ Current
Hepatitis ____	☐ Past	☐ Current	Stroke	☐ Past	☐ Current
High Blood Pressure	☐ Past	☐ Current	Tuberculosis	☐ Past	☐ Current
H.I.V. Positive	☐ Past	☐ Current	*Other:* _____		

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

Other Foot/Leg Problems:

Patient Initials: **Birthdate:**

PHARMACY / PRESCRIPTION INFORMATION

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

☐ Medco ☐ Other: _____

Address or Cross Streets	City	State	Zip Code

Phone Number ( ) ☐ This is a mail order pharmacy

MEDICATIONS

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

☐ **Check here if you are not taking any medications**

☐ **Check here if you have provided a separate list of medications**.

MEDICATION	DOSAGE

I give Kadin Foot and Ankle Center permission to access my medications electronically. ☐ Yes ☐ No

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

For Office Use Only:

HISTORY REVIEWED BY: DATE

KADIN
Foot & Ankle Center

Patient Name: _____ Date of Birth: _____

Name of Parent or Legal Guardian, if applicable: _____

I have **read and agree** to all the terms of the Financial Responsibility/Assignment of Benefits/Patient Responsibility Form (Rev 1/2019).

Signature of
Patient/Parent/Legal Guardian: _____ Date: _____

I have **read and agree** to all the terms of the Patient Responsibility For Follow-up Care Pledge (Rev 1/2019).

Signature of
Patient/Parent/Legal Guardian: _____ Date: _____

I allow my protected health information (PHI) to be discussed with the following person(s):

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **Other:** _____

Furthermore, I have **read and agree** to all the terms of the Patient Consent for Use and Disclosure of Protected Health Information (PHI) (Rev 1/2019).

Signature of
Patient/Parent/Legal Guardian: _____ Date: _____

KADIN
Foot & Ankle Center

FINANCIAL RESPONSIBILITY

(Rev 1/2019)

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: Starting at $10.00 each

(Other charges will apply for copies of records for personal use.)

ASSIGNMENT OF BENEFITS/PATIENT RESPONSIBILITY FORM

(Rev 1/2019)

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 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.

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

(Rev 1/2019)

I, above named patient, hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, a MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations.

Therefore, I understand that if I fail to see that specialist or to obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Rev 1/2019)

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.