

# PODIATRIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

E-Mail Address: \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Age: \_\_\_\_\_ Birthday: \_\_\_\_\_  
\_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced

Patient SS # \_\_\_\_\_ Race \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

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

Birthday: \_\_\_\_\_ SS# \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 3 PHONE NUMBERS

Home # \_\_\_\_\_ Cell \_\_\_\_\_  
Work # \_\_\_\_\_ Ext \_\_\_\_\_

Best time & place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

## 4

Describe the chief complaint to be treated.  
(Include foot, ankle, knee, thigh and hip)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been to a Podiatrist? \_\_\_ Y \_\_\_ N

Dr. \_\_\_\_\_ When \_\_\_\_\_

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

Your occupation \_\_\_\_\_

Cigarette/Tobacco \_\_\_ Y \_\_\_ N Yrs \_\_\_\_\_

Athletic activities & frequency \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

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

Insurance Co \_\_\_\_\_

Member # \_\_\_\_\_ Group # \_\_\_\_\_

Is Patient covered by Additional Insurance? \_\_\_ Yes \_\_\_ No

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

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

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

Insurance Co. \_\_\_\_\_

Member # \_\_\_\_\_ Group # \_\_\_\_\_

### **ASSIGNMENT AND RELEASE**

I, the undersigned certify that I ( or my dependent ) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Joseph Strickland 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 Hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

### **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Strickland for any services rendered me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible on for the deductible, coinsurance, and non-covered services. coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

## PODIATRIC HISTORY

Indicate the foot problems you have or have had in the past.

Ankle pain	___ Y ___ N
Athlete's foot	___ Y ___ N
Bunions	___ Y ___ N
Corns & Calluses	___ Y ___ N
Numbness in feet or legs	___ Y ___ N
Flat feet	___ Y ___ N
Cramps in feet or legs	___ Y ___ N
Heel pain	___ Y ___ N
Ingrown toenails	___ Y ___ N
Plantar warts	___ Y ___ N
Swelling ankles & feet	___ Y ___ N
Tired feet	___ Y ___ N

(OVER)

# 5

## MEDICAL HISTORY

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies to Anesthesia	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies to Medicine /Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valves/Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Special Diet	<input type="checkbox"/> Y <input type="checkbox"/> N
Back Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis or Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Neck Glands	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemical Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Varicose Veins	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Veneral Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Circulatory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervous Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Unexplained Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N
		Phlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N		

SURGERIES YOU HAVE HAD: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOSPITALIZATION OTHER THAN SURGERIES LISTED: \_\_\_\_\_

\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE # \_\_\_\_\_ LAST VISIT: \_\_\_\_\_

ARE YOU NOW, OR HAVE BEEN, UNDER ANY OTHER DOCTORS CARE FOR ANY REASON OVER THE PAST TWO YEARS?  Y  N

IF YES, PLEASE EXPLAIN \_\_\_\_\_

B/P \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

# 6

## MEDICATIONS & DOSAGE

INCLUDE PRESCRIPTION, OVER-THE-COUNTER AND VITAMINS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_

Are you on Oral Contraceptives?  Y  N

# 7

## ALLERGIES & REACTION

Codeine \_\_\_\_\_  
 Aspirin \_\_\_\_\_  
 Sulfa \_\_\_\_\_  
 Penicillin \_\_\_\_\_  
 Iodine \_\_\_\_\_  
 Novocaine \_\_\_\_\_  
 Seafood \_\_\_\_\_  
 Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Joseph H. Strickland, D.P.M.

Podiatric Physician and Surgeon

225 2nd Avenue N.  
St. Petersburg, FL 33701  
(727) 822-3573  
Fax: (727) 821-0626

9371 US Hwy 19 N.  
Pinellas Park, FL 33782  
(727) 579-0441

7926 W. Hillsborough Ave.  
Tampa, FL 33615  
(813) 887-1980

## FINANCIAL AGREEMENT

Dear Patient,

Thank you for choosing Dr. Joseph H. Strickland, D.P.M. as your podiatric health care provider. We are committed to the success of your treatment as well as providing you the best possible podiatric care. Please understand that payment of your bill is considered a part of your treatment. All patients must complete our Patient Registration form before seeing Dr. Strickland. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.**

### Regarding Medicare

We are a Medicare provider therefore we do accept assignment on Medicare. When possible your claim will be filed to Medicare and any supplemental insurance that routinely pays the doctor for his services. For those patients that have a supplemental that does not routinely pay the doctor or if you do not have a supplemental policy, we will require 20% of the bill to be paid at the time of service. If there is a remaining balance after your insurance pays, then a bill will be sent to you, for your payment of the final balance. Please be aware that some, and perhaps all of the service provided may be non-covered services and not considered medically necessary under the Medicare Program. Our staff recognized this and will attempt to take the time to discuss these charges with our prior to a service.

If you are a member of an insurance company that we are not participating with, we ask that you pay the full amount of the visit at the time of service. We will provide you a copy of your bill or help fill out a claim form so you can submit it to your insurance company.

### Miscellaneous Policies

24 hour notice may not always be possible but please call as soon as you realize you will not be able to make your appointment. Thank you for your understanding and cooperation.

Minors must be accompanied by a parent or legal guardian.

Returned checks are subject to a \$25.00 processing fee.

All accounts must be paid upon receipt of our bill. Payment options are available.

If you have any questions about the above information we will be glad to answer any questions.

I have read the Financial Agreement I understand and agree to the Financial Agreement.

I, the undersigned, authorize payment of medical and surgical benefits directly to Joseph H. Strickland, D.P.M and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Joseph H. Strickland, D.P.M. all rights to inquire on my behalf of any medical reviews relating to my medical benefits, either assigned or non-assigned claims.

\_\_\_\_\_  
Patient Name

X \_\_\_\_\_  
Signature of Patient/Responsible Party    Date

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## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATION.

By signing this consent, I acknowledge and agree as follows:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice:

To telephone my home to leave a message on my answering machine, or with the individual answering the phone.

The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that the Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this Consent at anytime, the Practice has the right to refuse to treat me. I understand that I do not sign this Consent evidencing my consent to the uses and disclosures described to be above contained in the Privacy Notice, and then the Practice will not treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

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Name of Patient (Printed)

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Signature of Patient or Guardian