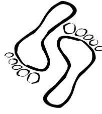
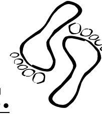



SOUTH AUSTIN FOOT ASSOCIATES, P.C.
PATIENT REGISTRATION FORM

PLEASE PRINT

Date: ____________________ Patient Name: ____

Social Security #: ____________________________________ DOB: ___________ AGE: ________ SEX: F M

Home Address: ____City/State: _______________________ Zip: _______

Home Phone # ( ) ________-___________ YES NO PRIMARY LANGUAGE: ________________

Alternate Phone # ( )_______-__________ YES NO SHOE SIZE: ___________________________

E-Mail: _______________________________ YES NO HEIGHT:______________ WEIGHT: ___________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ____________________________ RELATIONSHIP: __________________PHONE: _____________

EMERGENCY CONTACT: _________________________ RELATIONSHIP: __________________PHONE:_____________

PRIMARY CARE DOCTOR & PHONE #: ____

WHO REFERRED YOU TO US ___________________________

PHARMACY: ______________________ LOCATION: _______________________________ PHONE # _________________

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WANT US TO SHARE MEDICAL INFORMATION WITH?

_____YES _____ NO NAME: ____ PHONE: _______________________

RESPONSIBLE PARTY NAME: _________________________RELATIONSHIP: ______________ SS#: ________________

ADDRESS: _____________________________ CITY/STATE: _____________________ ZIP: _______PHONE: __________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: __________________________________ PHONE: ______________________

ADDRESS: _________________________________ CITY/STATE: ____________________________ ZIP: ______________

INSURED NAME: ________________________ DOB: _______________ SOCIAL SECURITY #: _____________________

IDENTIFICATION NUMBER: ____ GROUP: __________________________

SECONDARY INSURANCE COMPANY NAME: ______________________________ PHONE: _______________________

ADDRESS: _________________________________ CITY/STATE: ____________________________ ZIP: ______________

INSURED NAME: ________________________ DOB: _______________ SOCIAL SECURITY #: _____________________

IDENTIFICATION NUMBER: ____ GROUP: __________________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

MEDICATION NAME & DOSAGE HOW OFTEN DO YOU TAKE?

____

____

____

____

MEDICAL HISTORY

MEDICATION ALLERGIES: ________IF ALLERGIC, WHAT REACTION HAVE YOU HAD? ______________________

TAPE LATEX SHELLFISH IODINE FOODS ANESTHESIA _______________ OTHER _________

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

______________________ ______________________

______________________ ______________________

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

______________________ ______________________

______________________ ______________________

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
CURRENT USE – TYPE__________________ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT-HOW LONG AGO?___________ SMOKE____PACKS/DAY FOR_____YRS

USE OF RECREATIONAL DRUGS: NEVER QUIT-HOW LONG AGO? ______________ TYPE: _______________

CURRENT USE–TYPE __________________ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: ____ OCCUPATION: ________________________________

HOW MANY HOURS ARE YOU ON YOUR FEET AT WORK? ____

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _________ PET(S)-WHAT KIND________
ELDERLY OR DISABLED FAMILY MEMBER OTHER ____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: ____

.

REVIEW OF SYSTEMS:
PLEASE CHECK ALL THAT APPLY TO YOU

CONSTITUTIONAL (GENERAL)
__Weight loss/ + 10lbs __Weight gain/+15lbs __Fever __Chills __Fatigue __Nausea __Other______________________

Eyes, Ears, Nose & Throat:
__Impaired Sight __Eye Disease __Eye Pain __Vision Problems __Eye Infections-frequent
__Glaucoma __Hearing Loss __Ringing in Ears __ Ear Infections __Dizzy Spells
__Fainting Spells __Nose Bleeds __Sinus Problems __Sore Throat __Hoarseness
__Speech Problems __Dental Problems __Infected Teeth __Breathing Difficulty

Respiratory:
__Pneumonia __Pleurisy __Bronchitis __Asthma __Shortness of Breath
__Tuberculosis __Emphysema __Allergies __C.O.P.D __Limited exercise tolerance
__Use of Oxygen at home __History of smoking __Other_________________

Cardiovascular:
__Chest Pain __Heart Attack __High Blood Pressure __Low Blood Pressure __Open Heart Surgery
__Heart Murmur __Palpitations __Pace Maker __Rheumatic Fever __Angioplasty
__Varicose Veins __Phlebitis __High Cholesterol __Swelling of Ankles/Feet __Irregular Heartbeat/pulse
__Leg Pain/walking __Leg pain/Rest __Mitral Valve Prolapse __Blocked Arteries __Cold, Numb feet
__Congestive Heart Failure __Angina-increased Occurrence __Angina- new onset

Gastrointestinal_
__Loss of Appetite __Heart Burn __Excessive Hunger __Excessive Thirst __Difficulty Swallowing
__Peptic Ulcer __Crohn's/Colitis __Abdominal Pain __Gallbladder Problem __Liver Problems
__Vomiting __Hepatitis A __Hepatitis B __Hepatitis C __Cirrhosis
__Diarrhea __Diverticulosis __Acid Reflux __Bloody or Black Stools

Bladder, Kidney:
__Renal Failure __Swelling in Feet __Frequent Urination __Blood in Urine __Kidney Stones __Bladder Infections

Female: __Sexually Transmitted Disease __Breast Cancer __Ovarian Cancer __Oral Contraceptives

Male: __Sexually Transmitted Disease __Prostate Cancer __Other_________________________

Hematologic (Blood Disorders):
__Anemia __Bruise Easily __Cancer __Blood Transfusions __Sickle Cell Disease _On Coumadin __Abnormal Bleeding

Endocrine: __Diabetes __Thyroid Disease __Osteoporosis

Neurological (Nervous):
__Seizures __Tremors __Headaches __Trouble w/Balance __Change In Memory
__Stroke __Spine Disease __Numbness __Muscle Weakness __Polio
__Sciatica __Change in Sesation

Bone and Joint:
__Arthritis/Rheumatism __Back Pain/Recurrent __Gout __Osteoporosis __Severe Arthritis of TMJ
__Osteoarthritis __Rheumatoid Arthritis __Artificial Joints_________________

Skin:
__Rashes __New Growths __Psoriasis __Skin Cancer __Eczema
__Hives __Skin Cancer __Thick Scars __Color Change in moles or warts

Psychiatric:
__Agitation __Sleeping Disorder __Concentration Problems __Depression __Nervousness
__Memory loss __Moodiness __Suicidal Thoughts __Phobias __Mental Illness

Childhood Illness:
__Rheumatic Fever __Scarlet Fever __Chicken Pox __Mumps __Measles __Herpes

Immunology:
__HIV __Weak Immune System __Chronic Fatigue Syndrome __Frequent Infections

WHAT IS YOUR FOOT PROBLEM? ____

HOW LONG AGO DID THIS PROBLEM FIRST START? __________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING RADIATING ITCHING STABBING OTHER ______________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(*NO PAIN)* 0 1 2 3 4 5 6 7 8 9 10 **(WORST PAIN POSSIBLE)**

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE RUNNING OTHER ______________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________

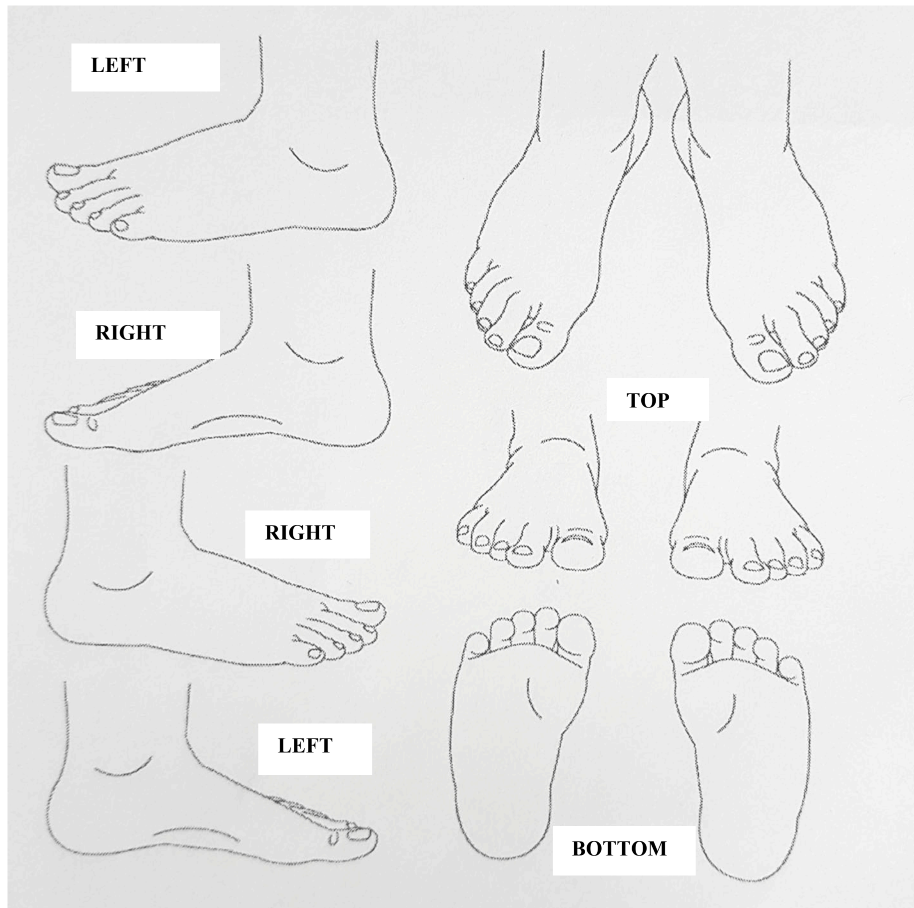
HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

____

WAS THIS PROBLEM CAUSED BY ANY INJURY? NO YES (DESCRIBE) ______________

______________ IF YES, WAS IT WORK-RELATED INJURY? YES NO

WHAT IS YOUR FOOT PROBLEM? WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON PICTURES BELOW.



AUTHORIZATIONS

__YES __NO I HEREBY AUTHORIZE MEDICAL BENEFITS TO BE PAID TO THE PHYSICIAN/OR SURGEON.

__YES __NO I ALSO UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE COMPANY.

__YES __NO I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION AND/OR MEDICAL RECORDS OF MYSELF, TO ANY TREATING PHYSICIAN, OR INSURANCE COMPANY.

__YES __NO THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING, HEPATITIS, SYPHILIS, GONORRHEA, HIV OR AIDS

__YES __NO I VOLUNTARILY REQUEST DR. BERGER OR DR. ZERINGUE, DPM AS MY PHYSICIAN, AND SUCH ASSOCIATES, TECHNICAL ASSISTANTS AND OTHER HEALTHCARE PROVIDERS TO TREAT MY CONDITION AS DEEMED NECESSARY.

__YES __ NO I AUTHORIZE SOUTH AUSTIN FOOT ASSOCIATES PC TO LEAVE INFORMATION AND APPOINTMENT REMINDERS AT THE FOLLOWING:

__ HOME____________________ / __WORK____________________ / __CELL___________________________

__YES __NO I GIVE SOUTH AUSTIN FOOT ASSOIATES PT PERMISSION TO RELEASE INFORMATION REGARDING MY HEALTHCARE INCLUDING, BUT NOT LIMITIED TO APPOINTMENTS, TEST RESULTS, DIAGNOSIS, ETC: WHETHER IN WRITING, ORAL, OR ELECTRONIC FORMAT TO THE FOLLOWING INDIVIDUALS LISTED BELOW(NAMES AND PHONE #)

***** **YOUR MEDICAL INFORMATION WILL ONLY BE RELEASED TO YOUR PHYSICIANS, THEIR STAFF(AS NECESSARY), AND OTHER PHYSICIANS AUTHORIZED TO PROVIDE YOUR CARE IF YOUR PHYSICIAN IS NOT AVAILABLE. YOUR HEALTH INFORMATION WILL ONLY BE RELEASE WITH YOUR CONSENT OTHERWISE ALLOWED UNDER STATE OR FEDERAL LAW. FOR EX: WE MAY SHARE LIMITED HEALTH INFORMATION TO HEALTHCARE PROVIDERS TO PROVIDE EMERGENCY SERVICES IF YOU ARE UNCONSCIOUS AND UNABLE TO PROVIDE CONSENT******

TO THE BEST OF MY KNOWLEDGE I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY, I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_______________________________________ _______________________________
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_______________________________________ _______________________________
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_______________________________________ _______________________________
SIGNATURE DATE

Patient Financial Policy

South Austin Foot Clinic is dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, ***you are responsible*** **for all authorization/referrals** needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- **Your insurance policy is a contract between you and your insurance company.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we **will look to you for payment.**
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an assigned basis. This means your insurer will send the payment directly to us. Therefore, you will receive a bill for any balance due.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "**not covered**", or you do not have an authorization you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, **YOU** remain the responsible for the charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For our services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- In the event you do not have medical insurance coverage and an elective surgical procedure is going to be performed at the hospital, we require pre-payment. You will be informed in advance if your procedure is one of those. In the event a procedure is to be done in the office, payment will be due at the time of surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and courts fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ______________________________

Printed Name: ______________________________ **Date:** ____________________

Witness: ______________________________ **Date:** ____________________

Printed Name: ______________________________

______________ Patients initials to indicate copy received.