Warrington Family Foot Care

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NEW PATIENT REGISTRATION

WELCOME! Thank you for choosing **Warrington Family Foot Care**

To assist us with your visit, kindly fill out the following information.

Today's date: _____

Patient Name:_____Date of Birth:_____

Age:_____ Sex: M/ F/ Other / Race:_____Primary language_____

Address:_____

Parents/Legal guardian of minor or Healthcare Power Of Attorney:

Name:_____Relationship_____Phone #_____

Emergency Contact Name :_____Phone #_____

Do you authorize us to discuss your health information with this person? Yes No

Your Primary Doctor_____Phone #_____Date of last visit _____

May we leave a message (text/voice) or send appointment reminders?

Home phone Y/N phone # ( )____-_____

Cell phone Y/N phone # ( )_____-_____

E-mail:_____

Insurance:

Please give **ALL** insurance cards to the receptionist so we can scan them to your chart.

Primary Insurance Company Name:_____

Secondary Insurance Company Name:_____

Responsible Party: **The person who supplies the patient's insurance or is responsible for payment if uninsured**

Name:_____ Date of Birth:_____

Relationship to patient:_____ Phone Number:_____

Address:_____

_____ **Please initial/date that you have read and entered the above information to the best of your knowledge, and that you will be responsible for updating any information necessary throughout your treatment to the physician/staff of Warrington Family Foot Care.**

Patient Name/DOB:_____ Today's Date: _____

REVIEW OF SYSTEMS (Circle if you currently experience any of the following):

Constitutional: sudden weight loss or weight gain, fever, fatigue Head headache, dizziness, vision changes

Cardiovascular: cold feet, night cramps, pain in calves when walking, pain in legs at rest, chest pain, swelling in legs Respiratory cough, difficulty breathing

Musculoskeletal: joint pain or aches, low back problems, weakness

Neurological: shooting or burning pain, numbness, tingling Psych depression, suicidal thoughts, forgetfulness, dementia, mood swings

Gastrointestinal: nausea, vomiting, upset stomach, indigestion

Skin: rashes, dry skin, itchiness, open sores, toenail fungus, nail changes, callus, plantar wart

PRESENT/ PAST MEDICAL HISTORY (Circle if you have/had):

Acid reflux	Diabetes Type 1 / Type 2	Neuropathy
Alcoholism	Depression	Open Sores/wounds
Alzheimers	Epilepsy/seizure	Parkinson's Disease
Anxiety Disorder	Eye problems	Polio
Arthritis	Eczema	Psychiatric care
Anemia	Fibromyalgia	Psoriasis
Artificial heart Valve	Gout	Rheumatic Fever
Heart disease	Headaches/migraines	Sexually transmitted
Asthma	Heart attack-When?_____	disease(Herpes,Syphilis)
Shortness of breath	Hepatitis A / B / C	Sickle cell
Back problems	HIV/AIDS	Sleep Apnea
Birth Defect	High or low blood pressure	Stomach ulcers
Bleeding, clot disorder	High Cholesterol	Stroke (CVA)
Cancer	Kidney disease	Thyroid disease
Chest pain	Liver disease	Tuberculosis
Circulation problems	Migraines	Other:

HOSPITALIZATIONS / SURGICAL HISTORY (Please include date/year of procedures):

_____

Implanted devices? Where? When?_____

Joint replacements? Where? How long ago?_____

Do you see any specialists? List name and phone # and Date last seen:

_____ _____ _____ _____

Medications (Please list Dose and how often you are taking or provide a List):

Prescription:_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Over the counter (Include Vitamins and other Herbal Supplements):

_____

_____

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Patient Name/DOB:_____ Today's Date: _____

Allergies:

Please list **ALL** allergies to food, medication(antibiotics, anesthesia), Latex,Tape,Iodine *AND* ***Reaction*** to these.

1._____Reaction:_____
2._____Reaction:_____
3._____Reaction:_____
4._____Reaction:_____

SOCIAL HISTORY:

I live with: no one spouse partner(boyfriend/girlfriend) children parents other
Tobacco or nicotine use: CURRENT: smoker Y/N Pack per day_____# of years_____
Former smoker quit date _____Former pack/day _____#of years_____
Alcohol use: Never/rare(<1drink/mo) Social/occasional Daily 1-2/day >4drinks/day
History of Alcohol abuse
Recreational or illicit drug use: Never Quit-When? What drug(s)_____
CURRENT use: Type_____How often? Rare Occasional Moderate Daily

Are you presently Employed? Yes No Disabled
If Employed, What is your occupation? _____
Employer?_____
How Much are you on your feet at work? 10% 25% 50% 75% 100%

Do You Exercise? Yes No How Often?_____Type of exercise?_____

Have you fallen recently? If yes, how many times in the last year? Were you injured?

_____

Do You have Advanced Directives? (circle all that apply)
Living Will DNR Durable Power of Attorney Surrogate Appointed None

Have you received any of the following vaccinations?
Covid 19 Yes No Date _____ Type: Moderna Pfizer J&J
Influenza (Flu) Yes No Date _____
Pneumoccocal (Pneumonia) Yes No Date_____

FAMILY MEDICAL HISTORY:

- ☐ **Diabetes-Type 1 or type 2 Who?_____History of toe/foot/leg amputation?_____**
- ☐ **Cancer-Type_____,who?_____Type_____who?_____Type?_____who?_____**
- ☐ **Heart Disease _____Who?_____**
- ☐ **Other_____**

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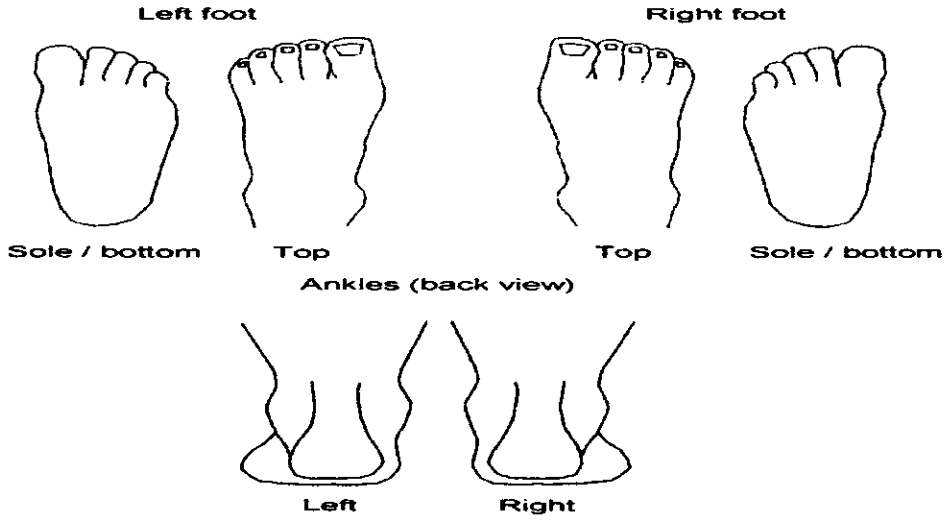
Patient Name/DOB:_____ Today's Date: _____

Specific Reason for your visit
Indicate location below:



When did this problem begin? _____
History of injury? Yes No Work-related? Yes No
If known injury, Briefly describe what happened?

_____

The problem is (circle): Improving Worsening Unchanged
What makes it worse? _____ What makes it better?_____
Pain Scale: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)
Duration of Pain: Constant Intermittent Occasional
When does pain occur?(circle) Day Night All day Only when walking Only when sitting
Describe the pain: Sharp Dull Achy Burning Shooting Clicking Cramping Itching
Describe previous treatment(self treatment or other): _____
Have you had Xrays MRI or other Imaging *for this problem*? Yes No
If yes, please provide copy of results or location and date of study_____

Anything else we should know about you/ your foot problem or *secondary* reasons or concerns for your visit?

_____

_____

What is your shoe size_____
If being seen for Diabetic Foot Screening/Care:
Who manages your Diabetes?_____What was your last HgA1c?_____

_____ **Please initial/date that you have read and entered the above information to the best of your knowledge, and that you will be responsible for updating any information necessary throughout your treatment to the physician/staff of Warrington Family Foot Care.**

HIPAA

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information by the Doctors and staff of Warrington family Foot Care: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you.
We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers.
Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.
We will not use or disclose your health information without your written authorization.
Uses and Disclosures Not Requiring Your Authorization in the following circumstances:
For certain limited research purposes; To the FDA to report product defects or incidents;For purposes of public health and safety; To authorities to prevent child abuse or domestic violence; To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; When required by court orders, search warrants, subpoenas and as otherwise required by the law.
Patient Rights: As our patient, you have the following rights:
To have access to and/or a copy of your health information;To receive an accounting of certain disclosures we have made of your health information;To request restrictions as to how your health information is used or disclosed; To request that we communicate with you in confidence; To request that we amend your health information; To receive notice of our privacy practices.
If you have any questions or objections to this privacy policy kindly ask to speak with our office manager or your physician.
Please sign below to acknowledge that you have read this notice of privacy.
Patient's Name (printed): _____
Patient's Signature: _____ Date: _____
If Patient is a Minor, Signature of Parent or Guardian: _____

If you would like to give someone clearance to discuss your medical records with please print their name here:
Name of whom we can discuss records: _____ Their Date of Birth: _____
Phone number: _____ Relationship to you: _____

CONSENT FOR PHOTOS: I give my consent to have photographs, videotaped images, or other images made of myself for chart records and advertising. I understand and agree to give unrestricted use to Warrington Family Foot Care or authorized persons for the purpose of: Teaching, includes being shown to other patients, advertisements, placement on websites, social media, scientific and/or research publications. Names will not be used, only images.
Sign only one:
_____ I hereby give consent to Warrington Family Foot Care & it's Associates to use my images
_____ I DO NOT give consent to Warrington Family Foot Care & it's Associates to use my images

CONSENT FOR E-PRESCRIBING & TO VIEW EXTERNAL PRESCRIPTION HISTORY: Warrington Family Foot Care will obtain the history of all of my past prescriptions and I understand that those prescriptions will become a part of my electronic health record. E-Prescribing (sending prescriptions electronically) greatly reduces medication errors and enhances patient safety.
_____ I provide informed consent to enroll me in the ePrescribe program
_____ I decline this option. I do not give permission for access to the above information, and only wish to have written prescriptions

*Pharmacy Name: _____
Address: _____ Phone: _____

Warrington Family Foot Care
Office Policies and Financial Agreement

The Doctors and staff of Warrington Family Foot Care are pleased you have chosen us for your foot and ankle care. Our staff strives to make your experience as pleasant as possible. To maintain a high level of care, the following policies are implemented:

Office Hours: For appointments, prescription refills and test results, please call our office during normal business hours. Prescription refills may take 1-2 days, so be sure to plan ahead. Antibiotics and narcotics may not be prescribed over the phone. We do not prescribe narcotics routinely, you may need to see a pain specialist instead.

Appointments: Occasionally, we encounter office emergencies or patients requiring more time. We hope you understand and accommodate for these rare instances that may delay your appointment time. If you feel you need to reschedule so that you can have the time and attention you deserve, please let us know.

Other: We encourage a respectful and professional environment for all who come through. We reserve the right to refuse care to patients who are rude or threatening to any staff member of Warrington family Foot Care.

Patient Financial Responsibility

****If you DO NOT have health insurance,** we warmly welcome self pay patients. Payment is due at the time of service. Fees can be discussed prior to or at your appointment time.

There will be a **$50 fee for all returned checks

- **If You DO have health insurance:**
  --Our relationship is *with you, the patient*, and not the insurance company. Therefore, if you have questions about your policy, contact your insurance carrier.
  --Cost/payments cannot be guaranteed since insurance policies are always changing. We will bill your insurance directly and any remaining balance will be billed to you.
  --Check with your insurance that our office is in-network. Additional charges may be applied by your insurance if we are out-of-network.
  --**Obtain a referral (if required by insurance)** from primary doctor prior to appointment
    - If this is not obtained by appointment time the patient will end up with a bill from that visit.
    - Know your copays, benefits and coverage (e.g. referrals, prior-authorizations, radiographs, lab tests)
- **Please bring your insurance cards to each visit and inform us of any changes in coverage, your address or phone number.**
- While we understand there may be times when you miss an appointment due to emergencies or illness, in order to be respectful to other patients requiring medical attention, please call to cancel or reschedule promptly. Late Cancellation/No-Show will be charged **$50**. Your insurance will not pay for this. Repeated no-shows and late cancellations may result in your care being transferred elsewhere
- There is an **administrative fee of $20 for completing forms** such as FMLA, DMV and disability.
    - Please **allow 5-7 working days** for your request to be completed.

- **Worker's Compensation and Auto Accident** cases MUST provide claim number, name of their carrier, date of injury, employer and number for their claim adjuster.
- **Medical Records** Per HIPAA guidelines, copies of your medical records need to be requested in writing using our Consent to Release Medical Records form. **The first set by email is free of charge. Paper copies will have a fee of a minimum of $10.**
- Any outstanding balance on an account **OVER 30 DAYS is subject to a 2% interest charge every month**
- **Insurance Release:** The entirety of the above information is true to the best of your knowledge. You, the patient or guardian, authorize use of your insurance benefits to be paid directly toWarrington Family Foot Care and to use your signature below on all insurance submissions required to process claims.

Please initial:

_____ **I have read the above (or had it explained to me) and agree to comply with the office policies and consent to treatment.**

_____**I agree to pay all fees and associated costs to collect outstanding balances, including any attorney fees, amount outstanding on my account.**

Thank you for your understanding and cooperation. We are delighted to serve you.

Printed Name of Patient	Signature of Patient	Today's Date

Guardian's Printed Name and Signature (Minors and POA)	Today's Date