Warrington Family Foot Care

NEW PATIENT REGISTRATION

WELCOME! Thank you for choosing Dr. Teresa Propato to be your provider!
To assist us with your visit, kindly fill out the following information to the best of your ability

Patient's legal name: _____
First Name **Middle** **Last Name**

I Prefer to be called:_____

Date of birth (mm/dd/yyyy): ___/___/_____ Age:_____ Sex: M / F / Other

Race:_____ Language_____ Marital Status: S / M / Divorced / Widow

Address:(Must match ID)

_____
Street/apt/po Box **City** **State** **Zip**

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

Name:_____Relationship_____Phone #_____

Emergency Contact Name :_____Phone #_____

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: Y/N _____

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:_____

Guarantor/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 #:_____

Indicates required field

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):

_____

_____

_____ **Please initial indicating you have read and answered the above questions**

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_____

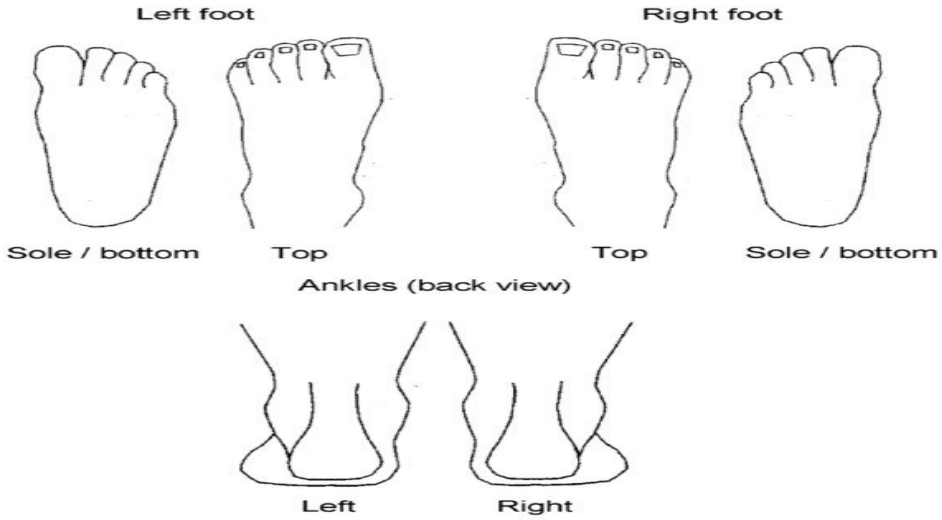
FAMILY MEDICAL HISTORY:

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

_____ **Please initial indicating you have read and answered the above questions**

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?_____

When was your last visit ?_____

_____ **Please initial that you have read and answered the above questions**

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

PRIVACY NOTICE

The Department of Health & Human Services has established a Privacy Rule to help ensure that personal health information is protected for privacy. The standards for the misuse of Personal Health Information (PHI) are designed to protect your information when disclosing information that is needed to carry out proper treatment, payment, or health care operations.

As one of our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When necessary, we provide the minimum amount of healthcare information to only those we feel is needed for your interest.

Please note that we support your full access to your Personal Health Information. **If you do not want someone to have your information, please inform our office so it can be noted in your chart.**

We will ask you to authorize release of your information to any party that is directly connected to your treatment, payment, or health care options.

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:_____

Signature:_____Date:_____

If Minor, Signature of parent of guardian:_____

An effort was made to get a signature but we were not successful. Date:_____

Privacy Information Preferences

Do you want to be exempt from public reporting?

- ❑ **Yes**
- ❑ **No**

Can we call the phone number(s) on file?

- ❑ **Yes**
- ❑ **No**

Can we leave a voicemail on the phone number(s) on file?

- ❑ **Yes**
- ❑ **No**

Can we send mail to the address on file?

- ❑ **Yes**
- ❑ **No**

Will you allow us to send e-mail AND/or TEXT MESSAGE appointment reminders to your cell phone?

- ❑ **Yes**
- ❑ **No**

Who can we leave messages with? Name:_____

Relationship:_____

Pharmacy Name _____

Address _____ Phone _____

Do you consent to the E-Perscribe program?

- ❑ **Yes**
- ❑ **No**

Do you give permission for Warrington Family Foot Care to obtain a history of your past prescriptions which will become part of your electronic medical record?

- ❑ **Yes**
- ❑ **No**

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

Warrington Family Foot Care
Office Policies and Financial Agreement

Thank you for choosing Warrington Family Foot Care 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 welcome self pay patients. Payment is due at the time of service. Fees can be discussed prior to or at your appointment time.

There is 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 coverage please contact your insurance carrier.
--Charges can be estimated by request but not guaranteed since insurance policies are always changing. – We will bill your insurance directly and any remaining balance will be billed to you.
--PLEASE know your insurance coverage and 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 your primary doctor prior to scheduling an appointment with us. If referral is not received by your appointment time YOU will end up with a bill for that visit.

- **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 $75 for a new patient and $50 for established patients**. **Your insurance will not pay for this. Repeated no-shows and late cancellations may result in termination.**
- **PLEASE NOTE:** 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
- **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 sent 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**
- **Any services not covered by your insurance are expected to be paid by the patient.**
- **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.

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.

Printed Name of Patient_____Signature of Patient_____
Date_____

Guardian's Printed Name and Signature (Minors/legal guardianship)_____
Date_____