Atlantic Health Partners
Affiliated with Atlantic Health System

GODOY FOOT & ANKLE CENTER REGISTRATION FORM

Patient Information

Today's Date_____

Name_____ Date of Birth_____ Age_____ Male | Female

Address_____ City_____ State_____ Zip_____

Email_____ Home #_____ Cell #_____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ American Indian/Alaskan Native. ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Decline

Employment Status: ☐ Employed _____ ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Primary care physician/pediatrician_____ Date last seen_____

What pharmacy/location do you use? _____

Emergency Contact_____ Relationship_____ Ph #_____

Responsible for Patient Account (put n/a if same)

Primary Insurance _____ Secondary Insurance_____

Policy Holder_____ Insured DOB_____ Relationship to patient_____

Financial Policy

1. The patient's insurance policy is a contract that exists between the patient and the insurance company. Our relationship is with the patient, and not the insurance company. It is the patient's responsibility to know the specifics of the policy (referral requirements, in and out of network physicians and facilities, Tier 1/Tiers 2, etc.). If you have questions about your policy, please call the number provided on the back of your insurance card.
2. We will call the patient's insurance to verify benefits, however, we are not responsible for incorrect information received which results in unexpected, out of pocket expenses. Payment by the insurance company cannot be guaranteed by our staff. The patient is responsible for payment and services rendered by our office.
3. All copayments must be paid at the time of service.
4. The patient is responsible of informing us of all insurances in effect and of any changes. Failure to do so will result in the patient being responsible for the cost of services rendered.
5. If the patient does not have insurance, has a non-participating plan, or is receiving services not covered by his/her plan, payment is required at the time of service.
6. **Missed or canceled appointments within 24 hours of the scheduled time will incur a $30 same-day cancellation fee.**
7. **Accounts that are past due by more than 90 days will be forwarded to a collection agency. A $25 administrative fee will be applied.**
8. **We require collection of outstanding balances prior to your next appointment. A $30 fee will be charged for all returned checks.**

_____ _____

Patient/Guardian Name (please print) Date

_____ _____

Patient /Guardian Signature Date

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Medical History

Weight_____ Height_____ Shoe Size_____

Do you have drug allergies? ☐ yes ☐ no If yes, please list the allergy & reaction_____

Please check the following if they apply to your medical history:

- ☐ Diabetes ☐ 1 ☐ 2
  Do you use insulin?
  _____
  Date
  diagnosed_____
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Anemia
- ☐ GERD
- ☐ Gout
- ☐ Cancer_____
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Heart disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney disease
- ☐ Bleeding disorders
- ☐ Neuropathy
- ☐ Circulatory Problems
- ☐ Jaundice/Liver disease
- ☐ HIV/AIDS
- ☐ Thyroid Disease
- ☐ Other _____
  _____

Medications (including vitamins and supplements. If you have a list, we will make a copy)

_____

_____

Surgical History (please list major surgeries & year)

_____

_____

Family History (parents, grandparents, siblings, children; living or deceased)

Disease/Condition	Yes	No	Relationship to you
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension	☐	☐	_____
Stroke	☐	☐	_____
Other (specify)_____	☐	☐	_____

Social History

Do you smoke cigarettes? ☐ yes ☐ no If yes, how much? ☐ 1 PPD ☐ 2 PPD ☐ other _____

If no, have you ever smoked? ☐ yes ☐ no If yes, how many yrs did you smoke? _____quit date? _____

Alcohol use: ☐ never ☐ 2-3 times per week ☐ 2-3 times per month ☐ 2-3 times per year

Other drug use? ☐ yes ☐ no If yes, what type? _____

I understand the completeness of this form is critical to receiving safe and effective medical care and I have completed the form to the best of my ability. I understand that it is my responsibility to inform Alps Road Family Foot & Ankle of any changes to my medical status. I hereby consent and authorize Alps Road Family Foot & Ankle and staff to perform any service deemed appropriate to make a thorough diagnosis. I also authorize Alps Road Family Foot & Ankle to perform any procedures, forms of treatment, medication and therapy in connection with my diagnosis and treatment plan.

_____ _____

Patient Name (please print) Date

_____ _____

Patient Guardian or Authorized Representative Signature

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What is your primary foot and/or ankle complaint today? _____

When did this start? _____ days _____weeks _____ months _____ years Is this: getting better | worse | unchanged

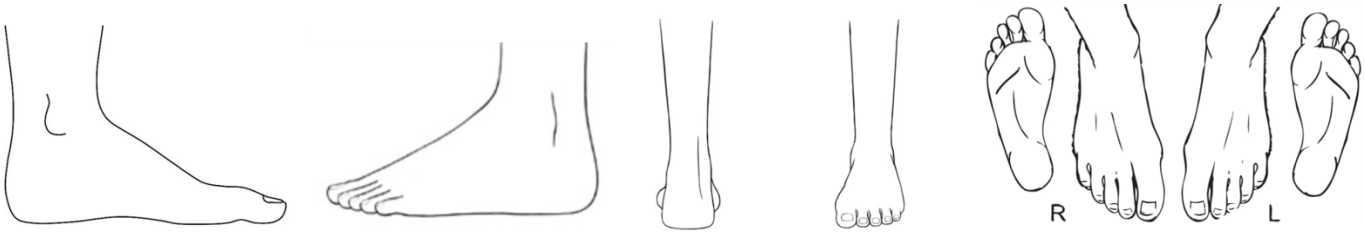
Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatments have you tried for this problem? _____

How would you describe your pain? (check all that apply)

☐ throbbing ☐ sharp ☐ radiating ☐ burning ☐ numbness ☐ dull ache ☐ sharp ache ☐ other_____

Please circle where your pain is located:



Please check any of the following symptoms that you have experienced in the past month:

Constitutional
- ☐ Recent weight gain_____
- ☐ Recent weight loss_____
- ☐ Fever
- ☐ Night sweats

Eyes
- ☐ Dry eye
- ☐ Vision change
- ☐ Eye irritation

ENMT
- ☐ Difficulty hearing
- ☐ Ear pain
- ☐ Frequent nose bleeds
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Snoring
- ☐ Dry mouth
- ☐ Mouth ulcers
- ☐ Teeth problems

Cardiovascular
- ☐ Chest pain
- ☐ Arm pain on exertion
- ☐ Shortness of breath when walking
- ☐ Shortness of breath when lying down
- ☐ Heart palpitations
- ☐ Heart murmur

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Sleep apnea

Gastrointestinal
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Poor appetite
- ☐ Diarrhea
- ☐ GERD

Genitourinary
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Hematuria
- ☐ Increased frequency

Musculoskeletal
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Arthralgias/joint pain
- ☐ Back pain
- ☐ Swelling in the extremities

Integumentary
- ☐ Rash
- ☐ Abnormal moles
- ☐ Jaundice

Neurologic
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ Tremors

Psychiatric
- ☐ Depression
- ☐ Sleep disturbances
- ☐ Feeling unsafe in relationship
- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Suicidal thoughts

Endocrine
- ☐ Fatigue

Hematologic/lymphatic
- ☐ Swollen glands
- ☐ Bruising
- ☐ Excessive bleeding

Allergic/Immunologic
- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing

GODOY FOOT AND ANKLE CENTER

NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. 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.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- 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.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices and HIPAA privacy authorization form and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____ _____

Patient Guardian or Authorized Representative Signature

GODOY FOOT & ANKLE CENTER

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information

To ensure your privacy, please answer the following questions and notify our staff if this information changes:

1. Do we have permission to leave a voicemail on the phone number you provided with us?
   ☐ Yes ☐ No
2. May we discuss your Medical Information with family and friends?
   ☐ Yes ☐ No

OR

Please list names of people we can discuss your medical care with:

Name	Phone Number	Relationship to patient

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell them you are here?
   ☐ Yes ☐ No

_____ _____

Patient Name (please print) Date

_____ _____

Patient Guardian or Authorized Representative Signature