Comprehensive Foot Care & Wellness Center

REGISTRATION FORM

(Please Print)

Today's date:	Dr. Kenneth Williams DPM	**Pharmacy # :**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status** (circle one) Single / Mar / Div / Sep / Wid

Language Primary ❑ Spanish ❑ English	Email:	**Ethnicity/Race:**	**Birth date:** / /	**Age:**	**Sex:** ❑ F ❑ M

Street address:	**Social Security no.:**	**Home phone :** ( )

City:	**State:**	**ZIP Code:**	Cell Phone: ( )

Occupation:	Employer:	Employer phone: ( )

Ok to leave messages with :	❑Patient only answers	❑Patient and/or spouse	❑any one who	Best time to Call:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Primary Doctor :	Address:	
Phone Number:	**Last Visit:**	Scheduled appointment:
Emergency Contact:	Emergency Phone :	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ BCBS	❑ Humana	❑ Superior
❑ Bravo	❑ Amerigroup	❑ Self Pay	❑ Private Insurance	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance :	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

MEDICAL HISTORY

(Please check below if you have any of the following.)

- **AID/HIV**
- **Anemia**
- **Angina**
- **Arthritis**
- **Artificial Heart Valves or Joints**
- Asthma
- Back Problems
- **Bleeding Disorders**
- **Cancer**
- Chemical Dependency
- Chest Pain
- Chronic Diarrhea
- **Circulatory Problems**
- **Diabetes**
- **Discolored Pigment (skin)**
- Ear Problems
- Epilepsy
- **Eye Problems**
- Fainting
- **Foot/Leg Cramps**
- **Gangrenous (black skin tissues)**
- **Gout**
- Headaches
- **Hemophilia**

Other:________________________

- **Hepatitis or Jaundice**
- **High or Low Blood Pressure**
- **Kidney Problems**
- **Liver Disease**
- **Neuropathy**
- Phlebitis
- Psychiatric Care
- Radiation Treatment
- **Rash**
- **Respiratory Disease**
- Rheumatic Fever
- Shortness of Breath
- Sinus Problems
- Special Diet
- **Stroke**
- **Swelling in Ankles and Feet**
- Swollen Neck Glands
- **Tired/Restless/Aching Feet or legs**
- Tuberculosis
- **Ulcers on Feet or Toes**
- Varicose Veins
- Venereal Disease
- **Weight Loss unexplained**
- **Other:**________________________

If you are Diabetic have you received any Diabetic foot wear? ***Yes*** ***No*** ***If yes when?***

Surgeries you have had

Hospitalized other than for the surgeries

Reason For today's visit

MEDICATION LIST

ALLERGIES

CONSENT FOR THE FOLLOWING

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Kenneth Williams or insurance company to release any information required to process my claims. I hereby consent and give permission to the doctor (and doctor assistants or designated replacement) to administer and perform such producers upon me as the doctor deems necessary.

Patient/Guardian signature *Date*

COMPREHENSIVE FOOT CARE
AUTHORIZATION AND CONSENTS

INITIALS	
______	**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS** I authorize Comprehensive Foot Care, to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic insurance, legal continuity of care, and medical treatment.
INITIALS	
______	**CONSENT FOR TREATMENT** As an adult and/or legal guardian, I do agree to permit the physician's and/or clinical staff at Comprehensive Foot Care, to provide medical to myself, my child, or the patient I represent as applicable. By signing below, id do agree to permit the physician and/or clinical staff to perform necessary or appropriate medical care including physical examinations, diagnosis, and treatment.
INITIALS	
______	**ASSIGNMENTS OF BENEFITS** I, hereby do authorize payment directly to Comprehensive Foot Care, for medical benefits otherwise payable to me. I do authorize my insurance company and/or the social security administration (Medicare) to disclose to Comprehensive Foot Care, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third-party payer.
INITIALS	
______	**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT** Your name and signature on this sheet indicate that you have read and have been offered a copy of the Comprehensive Foot Care, Notice of Privacy Practices (Notice on the date indicated) If you have any questions regarding the information in Comprehensive Foot Care Practices, please do not hesitate to contact a clinic representative or our Privacy Officer as indicated on your Notice.
INITIALS	
______	**RELEASE OF DATA** I GIVE CONSENT to ALL of the participating Providers to access ALL of my electronic health information through my designated insurance carriers Health Information Exchange (HIE) in connection with providing me any health care services, including emergency care and I GIVE CONSENT to the HIE to access ALL of my electronic health information through the HIE in connection with providing me any health care services, including emergency care.
INITIALS	
	RELEASE OF INFORMATION In addition, your name and signature below represent your Request and Authorization for Comprehensive Foot Care, to disclose information as specified by you the patient as noted in this Authorization. Do you authorize a family member or other person identified by you, the patient, to have access to your medical records/information? YES OR NO If yes , please specify family member or other person names that you authorize to your medical records and information. Name: ______________ Relationship: ______________ Phone: ______________ Name: ______________ Relationship: ______________ Phone: ______________

I have read and fully understand the Authorization for Release of Medical Records, Consents for Treatment, Assignment of Benefits, and Notice of Privacy Practices.

Print Patient Name: ______________________________ DOB: ______________

Signature of Patient: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________