

John M. Fanelly, DPM – Patient Registration and History

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ ZIP _____

Gender: M F Age _____ Date of Birth _____

Single Married Widowed Separated Divorced

Patient SS# _____

Patient Driver's License# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

How did you hear about our office? (select one)

Google/Internet Friend/Family Insurance Website

Doctor Referral (who?) _____

Other _____

3 PHONE NUMBERS

Home _____

Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

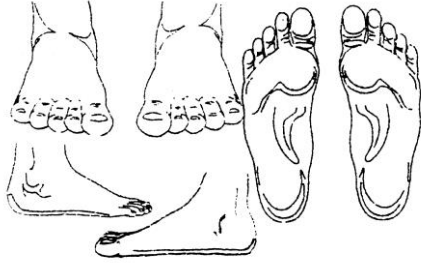
Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 PODIATRIC HISTORY

- What is the chief complaint for which you want to be treated? _____
- _____
- _____
- _____
- Describe Pain (if applicable):
- sharp/stabbing shooting grinding
- dull/achy radiating constant
- throbbing tingling burning
- comes & goes (how frequently?) _____
- other (please describe) _____
- _____

- Indicate where you are having these symptoms:



- How long have you had the symptoms?
- Did they begin suddenly or gradually?

- Have you tried anything that makes the condition better?
- What makes the condition worse?
- Have you tried any treatment for this condition?
- Have you been treated in the past for this condition? (if yes, when and by whom?)
- What is your goal for treatment?

2 PAYMENT ARRANGEMENTS

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Company or Self-pay _____

Subscriber Name _____

Subscriber's Date of Birth _____ SS# _____

ID# _____ Group# _____

Is patient covered by additional insurance? Yes No

Secondary Insurance Co. _____

Subscriber Name _____

Subscriber's Date of Birth _____ SS# _____

ID# _____ Group# _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above-mentioned insurance company and assign directly to John M. Fanelly, DPM all insurance benefits, if any, otherwise payable for me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

x

Responsible Party Signature _____

Relationship to Patient _____ Date _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to John M. Fanelly, DPM for any services furnished to me by that provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

x

Beneficiary (Patient/Insured) Signature _____

Relationship _____ Date _____

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot/Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves and/or Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in Ankles/Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis/Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss (unexplained)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other(s): _____		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
			Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

6 MEDICATIONS

Please list prescriptions, over-the-counter medications, and vitamins/supplements you are currently taking _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____


Do you take oral contraceptives? Yes No

7 ALLERGIES

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Adhesive/Tape | |
| <input type="checkbox"/> Other _____ | |

8 CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature  _____

Date _____