Columbus Podiatry & Surgery, Inc.

Columbus Podiatry & Surgery
Put Your Feet In Good Hands

Referred to:
Phone: (614) 885-3338
Fax: (877) 877-4797
Website: www.ColumbusFoot.com

Address: 117 Lazelle Road East Suite #B
Columbus, OH
43235

PDF ID#:

When is your appointment date: [ ] am [ ] pm

PATIENT REGISTRATION FORM

Physician Referred By:

PATIENT INFORMATION

First Name:	Middle:	Last Name:	Date of Birth:	Age:	
Gender:	SSN:	Race:	Ethnic:	First language:	Marital Status:
Mailing Address Line:	City:	State:	Zip Code:		
Home Phone:	Cell Phone:	Work Phone:			
Email Address:	Occupation:				
Employer:	Phone:				
Employer Address Line:	Employer City:	State:	Zip:		

PREFERRED METHOD OF COMMUNICATION

Method of communication:

WHOM MAY WE THANK FOR REFERRING YOU

TV Commercial [ ]	Newspaper [ ]	Magazine Ad [ ]	Yellow Pages [ ]
Radio Ad [ ]	Seminar [ ]	Our Web Site [ ]	Internet search [ ]
Other:	Patient:	Doctor:	Friend:

SPOUSE/GUARDIAN/SIGNIFICANT OTHER

First Name:	Middle Initial:	Last Name:	SSN:	
Address:	City:	State:	Zip:	Date of Birth:
Home Phone:	Cell Phone:	Employer:	Phone:	
Employer Address Line:	Employer City:	Employer State:	Zip:	

CONTACT IN CASE OF EMERGENCY

Contact Relationship:	First Name:	Last Name:
Home Phone:	Cell Phone:	Employer Phone:

Nearest relative or friend not living with you

Name	Relationship	Daytime Phone	Name	Relationship	Daytime Phone

Do you authorize this office to discuss your care or treatment with any party besides yourself: [ ] Yes [ ] No

Authorized Persons:

May we leave messages about your care or treatment appt using: [ ] Home Phone [ ] Work Phone [ ] Cell Phone

INSURANCE INFORMATION

Primary Insurance Type:				
Primary insurance:	Policy Number:	Phone Number:		
Policy holder's Name:	Date of Birth:	Home Phone:		
Address:	City:	State:	Zip:	Group Number:

SECONDARY INSURANCE INFORMATION

Secondary Insurance Type:				[ ] I have no Secondary Insurance
Secondary Insurance:	Policy Number:	Phone Number:		
Policy holder's Name:	Date of Birth:	Home Phone:		
Address:	City:	State:	Zip:	Group Number:

*** Signature Verification Code ***

FINANCIAL RESPONSIBILITY

Person Financially Responsible for Balance Not Covered by Insurance: [ ] Patient [ ] Spouse [ ] Parent [ ] Guardian

PHARMACY INFORMATION

Pharmacy Name:	Address:	Phone:

HEALTH INFORMATION

Reason for Visit:	Primary Care Doctor:

Please provide approximate date in which you were first aware of this problem:

ALLERGIES TO DRUGS OR OTHER SUBSTANCES

Allergy to	Reaction Type	Allergy to	Reaction Type

MEDICATIONS

Type, strength and times taken per day

Medication	Dose	Route	How often

PAST SURGICAL HISTORY

Hospitalization / Surgeries / Procedures

Type	Year	Type	Year

HEIGHT AND WEIGHT

What is your current height?

What is your current weight in pounds?:	Recent weight GAIN?: [ ] Yes	If so, how much in pounds?:
Kilos	Recent weight LOSS?: [ ] Yes	If so, how much in pounds?:

SOCIAL HISTORY

Do you live alone? [ ] Yes [ ] No	Education:	Occupation:
Do you have children: [ ] Yes [ ] No	If yes, how many:	Rate your alcohol consumption:
Have you ever smoked cigarettes or cigars:	If yes, how many packs per day (or equivalent):	For how many years:
How often do you exercise:	Number of caffeinated drinks per day:	[ ] Tea [ ] Coffee [ ] Soft Drinks [ ] Energy Drinks

FAMILY MEDICAL HISTORY

Are you adopted:			
Father living:	[ ] Yes [ ] No	Current Age (or age at death):	List cause of death or unknown:
Mother living:	[ ] Yes [ ] No	Current Age (or age at death):	List cause of death or unknown:

FAMILY MEDICAL HISTORY

Heart disease?:	[ ] Yes [ ] No	siblings	mother	father	grandparent
Heart attack/myocardial infarction/MI?		[ ]	[ ]	[ ]	[ ]
Heart Surgery/CABG/bypass?		[ ]	[ ]	[ ]	[ ]
Other:					
Diabetes:	[ ] Yes [ ] No	Please describe:			
High Blood Pressure/Hypertension:	[ ] Yes [ ] No	**siblings**	**mother**	**father**	**grandparent**
Hypertension/High Blood Pressure?		[ ]	[ ]	[ ]	[ ]
High Cholesterol/triglycerides/lipids?:	[ ] Yes [ ] No	**siblings**	**mother**	**father**	**grandparent**
High Chol/Lipids/Trig?		[ ]	[ ]	[ ]	[ ]
Multiple allergies or reactions:	[ ] Yes [ ] No	**siblings**	**mother**	**father**	**grandparent**
Had trouble with Anesthesia during a surgery, etc ?		[ ]	[ ]	[ ]	[ ]
Depression, Schizophrenia or mental problems	[ ] Yes [ ] No	Please Describe:			
Cancer?:	[ ] Yes [ ] No	**siblings**	**mother**	**father**	**grandparent**
Ovarian?		[ ]	[ ]	[ ]	[ ]
Breast Cancer?		[ ]	[ ]	[ ]	[ ]
Colon Cancer?		[ ]	[ ]	[ ]	[ ]

GYNECOLOGICAL REVIEW

Have you recently had any of the following signs and/or symptoms

Are you or could you be pregnant:	[ ] Yes [ ] No	Frequency of periods every (in days):	
Irregular cycles:	[ ] Yes [ ] No	Number of pregnancies:	
Abnormal Vaginal bleeding:	[ ] Yes [ ] No	Number of miscarriages:	
Late Period:	[ ] Yes [ ] No	Date of last cancer smear:	
First day of last period:		Result of last cancer smear:	
Age periods started:		Date of last mammogram:	
How many days do periods last:		Result of last mammogram:	

PERSONAL REVIEW OF SYSTEMS

Change in appetite:	[ ] Yes [ ] No	Change in Diet:	[ ] Yes [ ] No
Fever or Shaking Chills:	[ ] Yes [ ] No	Night Sweats:	[ ] Yes [ ] No
Severe sweating:	[ ] Yes [ ] No	Problems in sleep:	[ ] Yes [ ] No
Weakness:	[ ] Yes [ ] No	Fatigue/Excessive tiredness:	[ ] Yes [ ] No
Swollen glands/lymph nodes:	[ ] Yes [ ] No	Changes in body hair:	[ ] Yes [ ] No
Hot flashes:	[ ] Yes [ ] No	More cold natured:	[ ] Yes [ ] No
Hypoglycemic/low sugar:	[ ] Yes [ ] No	Increased thirst:	[ ] Yes [ ] No
Bleeding (gums, etc.):	[ ] Yes [ ] No	Bruising:	[ ] Yes [ ] No

Have you currently had any problems with the following?

Eyes:	[ ] Yes [ ] No	If yes describe:
Ears/Nose/Throat/Mouth:	[ ] Yes [ ] No	If yes describe:
Chest/Heart/Lungs:	[ ] Yes [ ] No	If yes describe:
GI tract/Stomach/Bowels:	[ ] Yes [ ] No	If yes describe:
Muscles/Bones/Joints:	[ ] Yes [ ] No	If yes describe:
Skin/Breast:	[ ] Yes [ ] No	If yes describe:
Brain/Nerves/Emotions:	[ ] Yes [ ] No	If yes describe:
Reproductive & Urinary System?:	[ ] Yes [ ] No	If yes describe:

Please check all that apply

Abnormal Bleeding	[ ]	Acid Reflux	[ ]	Anemia	[ ]	Alcoholism	[ ]	Arthritis	[ ]
Asthma	[ ]	Back Trouble	[ ]	Balance Problems	[ ]	Bladder Infections	[ ]	Blood Clots	[ ]
Blood Transfusions	[ ]	Bronchitis/Emphysema	[ ]	Broken Bones	[ ]	Bursitis	[ ]	Cancer	[ ]
Cramps or Numbness	[ ]	Diabetes	[ ]	Epilepsy	[ ]	Eye Problems	[ ]	Fibromyalgia	[ ]
Gout	[ ]	Heart Attack	[ ]	Heart Disease/Failure	[ ]	Hepatitis	[ ]	HIV+/AIDS	[ ]
High Blood Pressure	[ ]	Kidney Disease	[ ]	Liver Disease	[ ]	Low Blood Pressure	[ ]	Migraine Headaches	[ ]
Mitral Valve Prolapse	[ ]	Neuropathy	[ ]	Open Sores	[ ]	Osteo Arthritis	[ ]	Osteoporosis	[ ]
Pacemaker	[ ]	Parkinson's	[ ]	Patella/Femoral Synd	[ ]	Pneumonia	[ ]	Polio	[ ]
Reynaud's Syndrome	[ ]	Rheumatic Fever	[ ]	Rheumatoid Arthritis	[ ]	Skin Disorder	[ ]	Sickle Cell Disease	[ ]
Sleep Apnea	[ ]	Spider veins	[ ]	Spinal stenosis	[ ]	Stomach Ulcers	[ ]	Stroke	[ ]
Substance Abuse	[ ]	Thyroid Condition	[ ]	Tuberculosis	[ ]	Varicose Veins	[ ]		

PODIATRY SPECIAL INFO

Have you had or been treated for

Corns/Calluses [ ]	Leg or Foot Ulcers [ ]	Broken foot bone(s) [ ]	Hammer/Mallet toes [ ]
Cramp in legs/feet [ ]	Lower back pain [ ]	Gait (Walking) problems [ ]	Childhood foot problems [ ]
Warts [ ]	Fungal Nails [ ]	Neuroma [ ]	Broken Ankle [ ]
Bunions [ ]	Arch pain [ ]	Knee pain [ ]	In-toeing [ ]
Rash [ ]	Athlete's Foot [ ]	Ingrown nails [ ]	Foot Numbness [ ]
Ankle sprain [ ]	Flat feet [ ]	High arch feet [ ]	Heel pain [ ]
Toe walking [ ]	NONE of these [ ]	Nothing [ ]	

Did you previously or do you now wear

Shoe inserts: [ ] Yes [ ] No	Still using them: [ ] Yes [ ] No	Do or did they help: [ ] Yes [ ] No
Orthotics: [ ] Yes [ ] No	Still using them: [ ] Yes [ ] No	Do or did they help: [ ] Yes [ ] No

The orthotics were obtained from:	Do you get leg cramps: [ ] during the Day [ ] at Night
Are your first steps out of bed painful: [ ] Yes [ ] No	Does the pain then subside: [ ] Yes [ ] No
Percent of waking hours spent on your feet:	List the sports/type of dance you are active in:
Does foot pain limit your desired activities: [ ] Yes [ ] No	Do you have any difficulty in walking: [ ] Yes [ ] No
Any pain in calves or buttocks when walking: [ ] Yes [ ] No	Is the pain relieved by stopping and standing still: [ ] Yes [ ] No
Do you have vascular grafts: [ ] Yes [ ] No	Do you have joint implants: [ ] Yes [ ] No
Are your fingers or toes pale, discolored, or bluish? [ ] Yes [ ] No	Are your hands or feet cold to the touch: [ ] Yes [ ] No
Do you have numbness and tingling in your arm(s) or leg(s) or feet: [ ] Yes [ ] No	Sport(s): Years of sport participation: Training per week:
Recent 3-5 month intensity:	Time of day training:

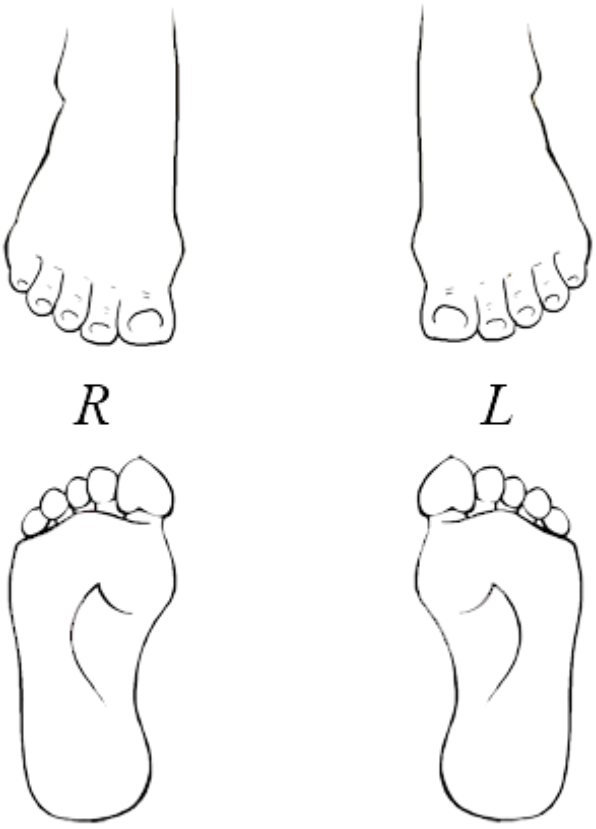
Shoes used

dress shoes [ ]	high heels [ ]	flat shoes [ ]	any closed toe shoe [ ]	running [ ]

Surfaces

gravel [ ]	pavement [ ]	sand [ ]	grass [ ]	padded [ ]
Shoe Size:				

FOOT PROBLEMS:



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:

I hereby authorize to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from our firm, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure not prohibit such redisclosure by the person or entity receiving my PHI from our firm. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

CATEGORY OF PHI:	All PHI	[ ]	Medical Records	[ ]	Billing & Claims	[ ]	Mental Health Records [ ]
	Drug/Alcohol Abuse	[ ]	HIV Test Results	[ ]	Genetic Test Results	[ ]	
AMOUNT OF PHI:	Entire PHI in the chosen category [Example - All "HIV Test Results"]						
	Please limit use and disclosure of my PHI to::						

The recipient(s) of my PHI is (are):

All Recipients [ ]	Primary Care Physician [ ]	Specialists [ ]	Current Healthcare Practitioner [ ]

Other:

I authorize my PHI to be used and disclosed at my request for:

DIAGNOSIS, TREATMENT, REVIEW AND REFERRAL:	[ ]	I understand that by checking this box, I give permission to use my PHI for the purpose of diagnosing, treating, reviewing, and referral.
CLINICAL TRIAL:	[ ]	

Authorization will expire 5 years form today unless specified:

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying our firm in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by our firm in reliance on this authorization before our firmreceives my request for revocation or modification. I must sign my written request and send it to:

Attn: Medical Records Department

Electronically Signed: [ ] Patient [ ] Parent [ ] Guardian	Date: Time:

ADDITIONAL COMMENTS

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named subscriber, hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID-Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date:	Patient:

Primary insurance:	Secondary insurance:
Policy number:	Policy number:
Policy holder:	Policy holder:

I request that payment of authorized MEDIGAP benefits be made on my behalf to for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release any information needed to determine benefits payable for related services.

Electronically Signed:	Date:
[ ] Patient [ ] Parent [ ] Guardian	Time:

MESSAGE TO INSURED PATIENTS

To All Insured Patients:

Welcome to .

We are pleased that you have chosen us to provide your medical care. We are always striving to provide you and your family with the best medical and professional service available.

Insurance companies sometimes deny claims because of lack of information on the patient's part and will not pay these claims until this information is given to them by you. If your insurance company has denied our claim because you have not given the information that they need to pay our claim, we may transfer the balance to your responsibility 30 days after being denied.

For those patients who are required to obtain a prior authorization to see us and do not obtain that authorization, we may also transfer the balance to the patient's responsibility.

It is our goal to provide you with excellent care, both medically and professionally. We need your cooperation and appreciate your prompt attention to this matter.

Thank you,

Insurance Department

Electronically Signed: [ ] Patient [ ] Parent [ ] Guardian	Date: Time:

DISCLAIMER

This Secure Registration is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution of this Secure Registration is prohibited. If you are not the intended recipient, please contact RegisterPatient.com and destroy all paper and electronic copies of the original registration forms.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number

Electronically Signed:	Date:	Time: