FRIEDMAN & GREENHUT, DPM, PA
PATIENT REGISTRATION FORM

Patient Information **Date** _____

Social Security # _____ DOB _____

First Name _____ MI _____ Last _____

Address _____ City, State, Zip _____

Home # _____ Cell # _____

Male □ Female□ Email _____

Single □ Married □ Widowed □ Divorced □

Veteran Yes□ No □

White □ Black or African American □ Hispanic Latino □

Asian □ Indian or Alaska Native □ Native Hawaiian □

Pharmacy Information

Pharmacy Name _____ Phone # _____

Address _____

Employer Information

Employer _____ Phone # _____

Occupation _____

Insurance Information

Primary Ins. Co. Name _____

Policyholder Name _____ DOB _____

Self □ Spouse □ Parent □

Secondary Ins. Co. Name _____

Policyholder Name _____ DOB _____

Self □ Spouse□ Parent □

Emergency Contact

Name _____ Relationship _____ Phone _____

Is your treatment today due to:

a work related injury	Yes □ No □	Injury date _____
a motor vehicle accident	Yes □ No □	Accident date _____
an accident / liability case	Yes □ No□	Accident date _____

FINANCIAL RESPONSIBILITY AND INSURANCE ASSIGNEMENT AGREEMENT

We make every effort to work within the guidelines of your insurance company in obtaining payment for you medical care. However, payment is ultimately your responsibility.

I understand that as a courtesy Friedman & Greenhut, DPM, PA will obtain benefit information from my insurance company and is in no means liable for any incorrect information given by the insurance company.

I understand that it is my responsibility to notify Friedman & Greenhut, DPM, PA of current insurance information. I further understand that if I fail to notify Friedman & Greenhut, DPM, PA of current insurance/billing information that I will be responsible for charges incurred due to outdated or termed coverage.

I understand that I am directly and fully financially responsible to Friedman & Greenhut, DPM, PA for charges not covered by my insurance. Payment for non-covered services is due at the time of service, I further understand that my co-payment or co-insurance is due at the time of service.

I understand that I am responsible for a $35 fee if I do not give a minimum of 24-hour notice for cancellation or if I do not show for my scheduled appointment.

LIFETIME ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

-I authorize Friedman & Greenhut, DPM, PA to bill my insurance company directly for payment. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Friedman & Greenhut, DPM, PA. This assignment will remain in effect until revoked by me in writing.

-I authorize Friedman & Greenhut, DPM, PA, its physicians, employees and agents to release all medical information including extremely confidential medical information if necessary to secure payment from my insurance company.

-I authorize Friedman & Greenhut, DPM, PA to provide a copy of my medical records to any medical facility/physician concerning my podiatry treatment.

X_____ _____

SIGNATURE OF PATIENT OR GUARANTOR DATE

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I Have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____
Patient Name (please print)

_____
Parent, Guardian or Patient's legal Representative

_____ _____
Signature **Date**

FAMILY MEDICAL RELEASE

I, _____, hereby authorize Friedman & Greenhut, DPM,

PA to release / receive the following information via phone or in person:

_____Appointments (Schedule/Cancel)
_____Office Notes
_____Financial
_____Prescription

To / From the following individuals:

_____
Name Relation

_____
Name Relation

_____ _____
Patient Signature **Date**

Patient Name: _____ **Date:** _____

Referring Physician Name and Phone: _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

   _____

2. **When did pain/discomfort begin (date):** _____

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ No ☐ Yes _____

5. **Have you had an accident?** ☐ No ☐ Yes _____

6. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No

7. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: _____

8. **Are you currently pregnant?** ☐ No ☐ Yes _____

9. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

   Surgery / Date: _____

   _____

10. **Social History:** (Only check what is pertinent to you)

    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits _____
    ☐ Caffeine Use ☐ Drug use (recreational, IV)

11. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes _____	☐ Heart Disease _____	☐ Kidney Disease _____
☐ Hypertension _____	☐ Stroke _____	☐ Mental Illness _____
☐ Rheumatology _____	☐ Bleeding Disorders _____	☐ Cancer _____

    ☐ Other family History: _____

12. **Height:** _____ Weight: _____ Shoe Size: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

Callahan Foot & Ankle Clinic
UNIVERSAL MEDICATION FORM

Date: ____________________

Name:	Address:
Phone Number:	
Birthdate:	

Primary Care Physician: ______________________________ **Date Last Seen:** ______________

Physician Phone Number: ______________________

Allergic To/Describe Reaction:	Allergic To/Describe Reaction:

List all prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: USE PATIENT FRIENDLY DIRECTIONS. DO NOT USE MEDICAL ABBREVIATIONS.	DATE STOPPED:	Reason for taking / MD Name