BFF
BEST FOOT FORWARD

New Patient Registration

Thank you for trusting Best Foot Forward with your foot health needs. We care about you and your privacy.

All information reported on this form will remain confidential in compliance with HIPAA guidelines.

Today's Date: _____

Name: _____ Date of Birth: _____

☐ Male ☐ Female SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Is it ok to call you at work? ○ Yes ○ No Do you work? ○ Full Time ○ Part Time ○ Student

Employer: _____ Employer's Address: _____

City, State, Zip: _____

Primary Care Physician/Phone Number: _____Last Seen Date:_____

Emergency Contact: _____

Relationship: _____ Daytime Phone: _____

Preferred Pharmacy Name and Zip Code: _____

INSURANCE (BFF requests copies of ALL insurance cards.)

Insurance Cardholder/Responsible Party Information	☐ **Same as above**
First and Last Name	
Date of Birth	
SSN	
Relationship to patient	
Home Address	
City, State, Zip	
Home Phone	
Work Phone	
Cell Phone	

Height: _____ Weight: _____ Shoe Size: _____

Referral Information: How did you hear about us?

Primary Doctor	☐	Insurance Company	☐
Newspaper	☐	Internet	☐
Brochure	☐	Personal Referral	☐
Driving by	☐	Other	☐

Describe: _____

Allergies

NO ALLERGIES	☐
Adhesive Tape	☐
Aspirin	☐
Codeine	☐
Meperidine	☐
Penicillins	☐
Sulfa Drugs	☐

Iodine	☐	Other (Please list below)
NSAIDS	☐	
Local Anesthetics	☐	
Shellfish	☐	
Latex	☐	
IV contrast dye	☐	
Fluoroquinolones	☐	
Cephalosporins	☐	

Describe reactions with severity:

_____

_____

_____

Medications (List all with dosages and directions or provide a copy)

_____

_____

_____

_____

_____

_____

Family History

Diabetes	☐	Stroke	☐	High Blood Pressure	☐
Cancer	☐	Heart Disease	☐	Other:_____ _____ _____	

Personal Health History

Diagnoses	YES	NO	Diagnoses	Yes	NO
HIV	☐	☐	Heartburn	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐
Artificial Heart Valve	☐	☐	Vascular disease	☐	☐
Asthma	☐	☐	Irregular Heartbeat	☐	☐
Bleeding Disorder	☐	☐	Kidney Disease	☐	☐
Blood Clots in Lungs	☐	☐	Are you on dialysis?	☐	☐
Blood Clots in Legs	☐	☐	Mitral Valve Prolapses	☐	☐
Cancer	☐	☐	Musculoskeletal Issues	☐	☐
COPD	☐	☐	Neuropathy	☐	☐
Diabetes	☐	☐	Psychiatric Disorders	☐	☐
Gallstones	☐	☐	Seizure	☐	☐
Gout	☐	☐	Stroke	☐	☐
Hepatitis A, B, C	☐	☐	Stomach Ulcer	☐	☐
Heart Attack	☐	☐	Thyroid Disorder	☐	☐
Heart Murmur	☐	☐	Varicose Veins	☐	☐

Social History

Do you use tobacco? ☐ Yes ☐ No Number of packs per day? _____

Former smoker quit date? _____

Do you drink alcohol? ☐ Yes ☐ No Number of Beers per week: _____

Number of Glasses of wine per week: _____ Hard liquor consumption: _____

Surgical History

Please list any prior surgeries with approximate years: _____

_____

_____

Podiatric History

Have you seen a podiatrist before? ☐ Yes ☐ No If yes, please complete the following information.

Doctor's Name: _____ Date of last visit: _____

Condition(s) for which you were treated: _____

Describe the specific problem that brings you to our office today: _____

_____

How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one: YES NO

If so, please list names below for our record. **Our office will only be able to communicate to the following persons:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Electronic access to prescriptions. Authorization to access Prescription history:

_____ Patient/Guardian **consents** to access to your online prescriptions (Full access)

(Select this if you want Best Foot Forward to view, send, and receive electronic prescriptions)

_____ Patient/Guardian **limits** consent to prescriptions by current provider only.

(Select this if you want Best Foot Forward to only handwrite prescriptions)

ASSIGNMENT and RELEASE: I certify that I have insurance coverage. I hereby assign direction to *Best Foot Forward* (BFF) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payment is made by insurance including, but not limited to, the deductible, co-payment, coinsurance, and any non-covered services. I understand that if my account is not paid when due, I will be responsible for all costs incurred during the collections process, including collection fees that are assessed. Co-insurance and deductible are based upon the amount of payment determined by my insurance carrier. I authorize *Best Foot Forward* to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made on my behalf to *Best Foot Forward (BFF)*, for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requires that payment be made and authorizes release of medical information necessary to pay the claim. If I have health insurance in addition to Medicare, my signature authorizes release of the information to the insurer or agency. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY: I give my permission to a Best Foot Forward Provider to administer such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric condition. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I certify that the above information is true and correct to the best of my knowledge.

Patient Name: _____

Signature: _____ Date: _____

Relationship to patient: _____

PAD Patient Intake Questionnaire

1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do you feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65?	Yes No
7	Are you over the age of 50?	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/or stent placement?	Yes No