# Affiliated Foot Care Center

## Podiatric Medicine & Surgery

## PATIENT REGISTRATION FORM

Date_____Soc. Sec#_____Birthdate_____ Male □ Female □

Last Name_____First Name_____ Middle Initial_____ Marital Status S M D W

Address_____Apt#_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Business Phone_____

Email_____

Employer_____Occupation_____

Business Address_____City_____State_____

Emergency Contact_____Phone#_____Relationship_____

Who referred you to our office? □ **Internet/Google** □ **Friend/Family** □ **Physician** If so, who?_____ □ **Insurance**

Primary Care Physician_____Phone#_____Date you last saw your Doctor_____

Address_____City_____Zip_____

Pharmacy Name_____Phone#_____

Address_____Phone#_____

Insurance Information

Policy Holder_____Relationship to Patient_____Birthdate_____

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REASON FOR TODAY'S VISIT- PLEASE INDICATE THE MAIN PROBLEM THAT BROUGHT YOU TO THE OFFICE

What is your MAIN foot problem today and are there others you would like to discuss?

_____

_____

When did your main problem begin?_____ Location of problem_____

Is **the pain** □ **Constant** □ **Intermittent? (explain)**_____

**Describe the pain:** □ **Sharp** □ **Dull** □ **Aching** □**Burning** □ **Throbbing** □**Other?**_____

What causes the problem or makes it worse?_____

**Was it caused by an injury?** □ **Yes** □ **No (explain if yes)**_____

Shoe Size_____Width_____Current Weight_____Height_____Do you wear orthotics? □ **Yes** □ **No**

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Have you had any serious illnesses, major injuries, or major surgeries? (If yes **explain on back)** □ **Yes** □ **No**
Are you under a physician's care? □ **Yes** □ **No** If yes, for what condition_____

PLEASE CHECK ALL THAT APPLY

Cardiovascular

- o Hypertension
- o Heart Attack
- o Stroke
- o Chest Pain
- o Irregular Heartbeat
- o Feet Swell
- o Varicose Veins
- o Leg pain with walking

Gastrointestinal

- o Heartburn
- o Acid Reflux/GERD
- o Blood in stools
- o Ulcer

Vision

- o Eye glasses
- o Impaired sight
- o Eye disease

Hematologic/Lymphatic

- o Bleeding disorders
- o Anemia
- o Enlarged Nodes
- o Do you take the following?
  - □**Aspirin** □**Coumadin**

Musculoskeletal

- o Arthritis
- o Joint pain
- o Fractures
- o Muscle cramps

Integumentary (Skin)

- o Latex allergy
- o Rash
- o Eczema
- o Psoriasis
- o Moles
- o Skin Cancer
- o Deformed nails

Endocrine

- o Diabetes If yes, Insulin? □ **Yes** □ **No** How many years?_____

Respiratory

- o Lung problems
- o Coughing phlegm
- o Wheezing
- o Shortness of Breath
- o Asthma
- o Emphysema

Nervous System

- o Numbness
- o Dizziness
- o Muscle Jerking
- o Seizure
- o Depression
- o Weakness
- o Brain disease
- o Migraines
- o Forgetfulness
- o Spinal Disease

Family History

- o Epilepsy
- o Gout
- o Hypertension
- o Heart Attack
- o Kidney Disease
- o Diabetes
- o Allergies
- o Cancer
- o Spinal disorder
- o Mental illness
- o Arthritis

| Medications | Dosage |
|---|---|
| | |
| | |
| | |
| | |

***LIST DRUG ALLERGIES: ☐ CHECK BOX IF YOU HAVE NO KNOW DRUG ALLERGIES****

| Medication | Reaction | Severity |
|---|---|---|
| | | □MILD □MODERATE □SEVERE |
| | | □MILD □MODERATE □SEVERE |
| | | □MILD □MODERATE □SEVERE |
| | | □MILD □MODERATE □SEVERE |

**SMOKING STATUS: ☐ NON SMOKER**

**☐SMOKER ____PACKS per DAY**

**☐PAST SMOKER ___PACKS per DAY**

**ASSIGNMENT AND RELEASE**

**I hereby authorize payment directly to Dr. Gordon E. Fosdick and/or associates all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.**

**I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submission.**

**Signature of Responsible Party_____Date_____**

## AFFILIATED FOOT CARE CENTER, LLC

## Gordon E. Fosdick, DPM

*Diplomate, American Board of Podiatric Surgery, Board Certified in Foot Surgery*


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**470 Main St., P.O Box 221**
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**Wallingford Office**
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**Wallingford, CT 06492**
**P (203)294-4977**
**F (203)294-0045**


### SUMMARY OF NOTICE OF PRIVACY PRACTICES

***The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices is available for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.***

1. **Uses and Disclosures of Your Health Information: We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.**
2. **Other Uses and Disclosures: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on authorization.**
3. **Your Health Information Rights: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice.**
    a) **You may request restrictions on certain uses and disclosures of your information**
    b) **You may request that you receive your information for us in a certain way**
    c) **You may inspect and copy your medical records**
    d) **You may request an amendment to any record your believe is inaccurate**
    e) **You may request an accounting of disclosures made of your records**
4. **Changes to the Notice: We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.**
5. **Complaints: You may file a complaint to our Privacy Official whose name is above or with federal government as detailed in the Notice. You will not be penalized for filing an complaint.**

**Policy has been made available to me for review.**

**Signature:**_____**Date**_____

**Print Name**_____