ADVANCED FOOT & ANKLE CENTER

Physician Name:	*Department Location:*

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone: ( )

City/State/Zip Code:	Cell phone: ( )	Work phone: ( )

Email address:	Emergency contact name:	Emergency phone:	Emergency contact relation:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Name of Parent / Guardian:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Address: Street / City / State / Zip Code: (IF SAME AS PATIENT – CHECK HERE ❑)

GUARANTOR INFORMATION

Guarantor responsible for bill:	Birth date: / /	SSN:	Guarantor phone no: ( )

Relationship of Guarantor:	Guarantor address : (IF SAME AS PATIENT – CHECK HERE ❑)	Guarantor Employer: ( )

1ST INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Name of primary insurance (if applicable):	Insurance Address:	Insurance Phone: ( )	Type of Insurance: ❑ Medicare ❑ Private

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	IS THIS A WORK RELATED INJURY? _____

2ND INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

DISCLOSURES / AUTHORIZATIONS

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorized payment directly to the Physician for any amount due to me for professional services, including major medical, under this claim. The authorization is to remain in effect until revoked by me in writing. I further authorize you to notify directly to the Physician of any rejections of this claim. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges on any professional services rendered.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information necessary to process claims and collect payment for services rendered.

PATIENT / GUARANTOR SIGNATURE: **DATE:**

ADVANCED FOOT & ANKLE CENTER

□ BRIAN LOYDE INLOW, DPM

□ 5 Harris Court, BLDG T, Ste. 103
Monterey, CA 93940
Tel (831) 373-3839
Fax (831) 375-8804

□ DEANNA L. INLOW, DPM

□ 321 East Romie Lane
Salinas, CA 93901
Tel (831) 424-0313
Fax (831) 424-2192

Patient Name:_____ Weight:_____ Height:_____ Shoe Size:_____

HEALTH QUESTIONNAIRE

1.) **Do you have any allergies to drugs or foods?** If yes, please list _____ YES NO
_____

2.) **Do you have hay fever or asthma?** YES NO

3.) **Are you currently taking any medications**? YES NO
**** Please list all medications on attached sheet*

4.) **Do you have a family physician or a private physician** YES NO
Please list name & address:_____

5.) **Please circle any of the following illnesses which you have and/or had**:
Heart disease (murmur, heart failure, arrhythmia, heart attack), hypertension (high blood pressure), Asthma, rheumatic fever, emphysema, tuberculosis, pneumonia, diabetes, stomach ulcer, hepatitis, Jaundice, anemia stroke, seizures (convulsions), phlebitis (blood clots in veins), recurrent infections (bladder, prostate, kidney, sinus, respiratory), tumor or growth

6.) **Have you had any previous surgery**? YES NO
Please list all surgeries:_____

7.) **Have you had any problems with anesthesia**? YES NO

8.) **Have you have any problems with abnormally easy bleeding**? YES NO

9.) **Have you had any major traumas (fractures, etc.)**? YES NO

10.) **Have you been hospitalized over the past two years**? YES NO

11.) **Do you have any known contagious diseases**? YES NO

12.) **Have you been treated for exposure to the AIDS virus**? YES NO

13.) **Women**: **Are you pregnant or think you may be pregnant**? YES NO

14.) **Habits: Do you smoke**? YES NO
Number of packs per day:_____ Number of years:_____

15.) **Do you use alcohol**? YES NO
If so, which type: Beer Wine Hard Liquor How much per week?_____

Please provide other health information you deem important:

_____

_____

SIGNATURE: _____ DATE: _____

ADVANCED FOOT & ANKLE CENTER

□ BRIAN LOYDE INLOW, DPM

□ 5 Harris Court, BLDG T, Ste. 103
Monterey, CA 93940
Tel (831) 373-3839
Fax (831)375-8804

□ DEANNA L. INLOW, DPM

□ 321 East Romie Lane, Ste. A
Salinas, CA 93901
Tel (831) 424-0313
Fax (831) 424-2192

* MEDICATION LIST *

Patient Name: _____ Date of Birth: _____

[ ] I AM CURRENTLY NOT TAKING ANY MEDICATIONS

Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____
Prescription: _____ Dosage _____ Times per day _____

Patient Signature: _____ DATE: _____

ADVANCED FOOT & ANKLE CENTER

□ BRIAN LOYDE INLOW, DPM

□ 5 Harris Court, BLDG T, Ste. 103
Monterey, CA 93940
Tel (831) 373-3839
Fax (831) 375-8804

□ DEANNA L. INLOW, DPM

□ 321 East Romie Lane
Salinas, CA 93901
Tel (831) 424-0313
Fax (831) 424-2192

Patient Consent for Use & Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by Dr. Brian Loyde Inlow, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. If provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be required when you are being seen as a patient, by asking our receptionist at the front desk.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purpose of treatment, payment and health care options.

_____

Signature of Patient or Co-Responsibility of party Date

Relationship to Patient/Legal Authority (*if applicable):*_____

FOR PRACTICE USE ONLY

Failure to obtain consent (check the appropriate reason):

□ Indirect Treatment Relationship □ Emergency treatment

□ Substantial Communication Barrier □ Refusal to sign □ Other

Description:_____

_____ _____
Practice Signature Date

_____ _____
Witness Date