FOOT CENTER of NEW YORK
55 EAST 124th St. NY, NY 10035
Phone 212.410.8158
Fax 212.410.8166

REGISTRATION FORM

Chart # ____

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 no.: ( ) Cell phone no.: ( ) Email Address:			
P.O. box:	City:	State:	ZIP Code:		
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	
Other family members seen here:					
PRIMARY CARE PHYSICIAN NAME: **ADDRESS:** **TELEPHONE :**					

PHARMACY INFORMATION

Pharmacy Name:	Address:	Phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here?	❑ Yes	❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance?	❑ Yes	❑ No			
Please indicate primary insurance	❑ Aetna	❑ BC/BS	❑ Cigna	❑ GHI	❑ HIP
❑ 1199	❑ United Healthcare	❑ Oxford	❑ Medicaid	❑ Medicare	❑ Other
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	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I consent to the diagnostic and treatment procedures to be provided by the podiatric and/or medical staff and other personnel of this clinic.

Patient/Guardian signature ________________________ *Date* ____________

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MEDICAL HISTORY (PLEASE CHECK ANY CURRENT OR PRIOR CONDITIONS)							
Cancer		Leg/Foot swelling		Fractures Specify: _______________		Hernia	
Diabetes		Congestive heart failure		Arthritis		Heartburn/reflux	
High blood pressure		Leg/Foot numbness		Sprained ankle/foot		Stomach ulcer	
High cholesterol		Burning or tingling		Rheumatoid arthritis		Jaundice	
Heart attack		Sciatica		Fibromyalgia		Pancreatitis	
Stroke		Weakness		Neuromuscular disease		Asthma	
Blood clots		Seizures		Frequent urinary infections		Emphysema	
Poor circulation		Back pain, hip/knee pain		Kidney disease or dialysis		Pulmonary ambrosias	
HIV		Hepatitis		Rheumatic fever		Cellulites or Gangrene	
Blood poisoning		Polio		Depression		Anxiety	
Bipolar Disorder		Developmental abnormality Specify:_________________		Allergies Specify:____________________			

What medications are you presently taking 1.________________________ 2.__________________________ 3.____________________________

Reason for visit today ____ Duration ________________________________

Is the problem related to a: car accident Y or N OR work related Y or N

1.**Financial Responsibility:**
I agree to be fully responsible for all bills of all the services given to me at The Foot Center of New York.

2. **Approval Of Use of Authorization Copy**:
I approve of a copy this authorization being used instead of the original.

3. **Assignment Of Insurance Benefits:**
I request payment of medical insurance benefits to myself or to the party named above who accepts assignments.

4. **Authorization For Release of Medical and Other Information Related To Patient:**
I authorize The Foot Center of New York to release medical or any other information about me to Medicare, its intermediary, or other commercial insurance companies.

5. **Acknowledgement of Receipt of Privacy Notice:**
I acknowledge that I was provided a copy of the Notice of Privacy and that I have read (or had the opportunity to read if I so choose) and understood the notice.

ORIGINAL SIGNATURES	
Patient/Guardian signature	*Date*
Witness signature	*Date*

Registration Completed By____