JOHNSTON FOOT & ANKLE CLINIC PATIENT REGISTRATION SHEET

Patient Information

First ____________________ Last _______________________ M _____________ Date of Birth __________________

Address _____________________________________ City _________________ State ________ Zip _______________

Home# _____________________ Cell # ___________________ Email: ____________________________________

Please Circle: Male or Female Social Security # ________________________ Language _______________________

Please Circle Marital Status: Single/Married/Divorced/Widowed/Partner **Ethnicity:** Hispanic/Latino or Non-Hispanic

Please Circle Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Islander White

Primary Care Physician _______________________________________ **Date Last Seen** _______________________

Employer Name, Address, Phone #:

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Responsible Party (Guarantor) You do not need to fill out if you are the insured

First _________________ Last ___________________________ M _________ Date of Birth _____________________

Address ___________________________________ City ________________ State __________ Zip _______________

Home # _______________________ Cell # _____________________ Email: _________________________________

Social Security # _________________________ Relationship to patient _____________________________________

How did you hear about our office? ____

Emergency Contact ____ **Phone #** _________________________

Do we have permission to talk to this person regarding your health? Yes / No

I/We do hereby consent to and authorize the performance of any/all treatments, surgeries and/or medical services deemed advisable by Dr. Dana L. Plew, DPM at Johnston Foot & Ankle Clinic, to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that to the best of my knowledge, all statements contained heron are true. I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Johnston Foot & Ankle Clinic to release any/all information requested by insurance companies and/or its representatives, collection agencies and/or any attorney's office and/or any physician, surgery center or hospital. The signature below will also count as my "signature on file" for any/all insurance purposes. I fully understand this agreement and consent will continue until cancelled by me in writing.

Print Name of Patient/Responsible Party

____ ***Date*** ________________________

Signature of Patient/Responsible Party

____ ***Date*** ________________________

Pharmacy Name/Address____

Please list any/all medications and dosages: *I do not take any medications* □

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Please list any/all allergies to medications: *No Known Allergies* □

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Past Medical History: *Please circle any/all that apply*

*None Allergies/Medicine Anxiety/Depression Arthritis Asthma A-Fib Cancer CAD COPD Crohn's Diabetes Gallbladder GERD Heart Hepatitis C High Blood Pressure/Low Blood Pressure High Cholesterol Liver Migraines Thyroid Other*______________________________

Past Surgical History: *Please circle any/all that apply*

None Adenoidectomy Angioplasty Appendectomy Arthroscopy Knee right/left/both Back Breast C-Section Carpal Tunnel Release right/left/both Cataract Colon Foot right/left/both Gastric Bypass Hernia Hip right/left/both Hysterectomy Kidney Knee right/left/both LASIK Liver Pacemaker Prostrate Thyroidectomy Tonsillectomy Tubal Ligation Vasectomy Other: ________________________

Family History: *Please circle any/all that apply*

Cancer- mother/father Diabetes- mother/father Heart Disease- mother/father Stroke- mother/father

Social History: *Please circle any/all that apply*

Smoker Yes/No *How much do you smoke?* _____

Caffeine Yes/No *How much do you drink?* _____

Have you had any of the following vaccines? ***Flu/Pneumonia/Shingles***

What is your: *Height* ____________________ *Weight* ____________________

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that requires all medical records and other individual health information that is used or disclosed by us in any form (on paper, electronically, or verbally) are kept properly confidential. In summary, HIPAA gives you the following rights.

- The right to request on certain uses and disclosures of protected health information including disclosures to family members, other relatives, close personal friends or any other personal identified by you.
- The right to reasonable requests to receive confidential communications of protected health information to us.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of our Notice of Privacy Practices.

We may disclose your medical records for each of the following purposes:

- **Treatment: This includes providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may disclose protected health information to your family physician, diabetic physician, referring physician or any other physician that treats you.**
- **Payment: This involves such activities as obtaining reimbursement for services, confirming insurance coverage, billing agency, collection agency, or credit agency, and utilization review. For example, we may provide protected health information to your insurance company.**
- **Health Care Questions: This includes the business of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example, we may utilize protected health information for a quality assessment review.**

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by that written request. If you feel that our privacy protections have been violated, you have the right to file a written complaint with our office or with the Department of Health and Human Services.

I acknowledge that I was provided a chance to read or a copy of the Notice of Privacy Practices and that I understood the notice.

Patient name (Please Print) ______________________________

Patient signature ______________________________ *Date* ________________