Patient Registration

Patient Full Name		Date of Birth			
Address					
City		State		Zip	
Email					
Emergency Contact		Phone			
Relation					
Responsible Party (if other than Patient)					
Full Name		Date of Birth			
Address					
City					
Home Phone		Cell Phone			
Email		Patient SS#			
Patient/Responsible Party Employment					
Employer		Occupation			
Employer Address					
City		State		Zip	
Work Phone					
Insurance Information					
Insured: (if different from Patient)		Occupation			
Relationship to Patient (circle one)	self	spouse	child	other dependent	
Primary Health Insurance					
Member ID		Group #			
Secondary Health Insurance					
Member ID		Group #			
Co-Pay Amount					

Denton Podiatry
Foot and Ankle Specialists

Patient Medical Information

Patient Name		Date of Birth	
Please Circle	Male Female		
Primary Care Provider			
Name/Clinic			
Phone		Last Seen	
Relation			
What foot problem(s) are you having?			
Allergies to Medications			
List all medications, Including over-the-counter medications, vitamins/minerals, and supplements:			
Do you smoke	Yes No Former Smoker (______ Year)		
Alcohol consumption	None Occasional Frequently Daily		
Are you Pregnant	Yes No		
Family History: (Please Circle)			
High Blood Pressure Diabetes Cancer Stroke Heart Problem Arthritis Unknown			
Surgery History: (Please Circle)			
Heart surgery Joint replacement Vascular Surgery Back Surgery Gastric Bypass None			
Other Surgeries:			

Denton Podiatry
Foot and Ankle Specialists

Patient Medical Information

Medical History			
Patient Name		Date of Birth	

Personal Medical History:

Anemia	High Blood Pressure	Anaphylaxis
Artificial Joint	Stroke	Hepatitis/Liver Disease
Cancer	Bleeding Disorder	Kidney Disease
Emphysema	Tuberculosis	Lung Disease
Arthritis	Gout	Osteoporosis
Asthma	Thyroid Disease	Low Back Pain
Chest Pain	Psychiatric Care	Poor Circulation
Epilepsy or Seizure	Stomach Ulcer	Blood Clots/DVT
Glaucoma	Neuropathy	Foot Ulcer
Heart Conditions	Atrial Fibrillation	MRSA Infection

Diabetes	Yes	No

(if yes please provide the following information)

Cirlcle One: Type 1 Type 2

Doctor (if different than Primary Care Provider)					
Date Last Seen		Last A1C		This Mornings Blood Sugar	

Diabetic Medication: (Please Circle)

Insulin Orals Both Neither

Have you had foot surgery due to Diabetes	Yes	No

Other conditions, or important Information we should know about:

Weight		Height		Shoe Size	
Pharmacy		Location			

Consent for Treatment

Patient Name		Date of Birth	

I consent to evaluation and treatment of the condition for which I, my child/dependent, have come to Denton Podiatry, PLLC for and authorize the physicians and other health care providers affiliated with Denton Podiatry, PLLC to provide treatment. I acknowledge and agree that this consent will be applicable to all visits of evaluation and treatment. I take responsibility for payment of the treatment to me/my child/dependent. I authorize Denton Podiatry, PLLC to bill and be paid directly by any such insurer for all charges incurred in connection with the diagnosis, care, and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, copayment, co-insurance, or charges not covered by my health insurance. I understand that certain payments may be required at the time of services are rendered. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.
- I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying Denton Podiatry, PLLC for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I default or do not pay for treatment provided, I acknowledge and agree that Denton Podiatry, PLLC is entitled to recover the full amount of the debt owed for medical services, collection expenses, and attorney fees charged to Denton Podiatry, PLLC to complete the collection.

Patient Rights and Responsibilities:

I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand. I agree to provide accurate and complete information about my health history and presenting complaint. It is my responsibility to agree upon a treatment plan and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

I have read, understood and fully agree to each of the above statements and sign below as my free voluntary act.

Signature of Patient/Responsible Party: ______________________________ Date: ______________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Patient also agrees to:

  -Allow phone calls, e-mails, and texts for communication purposes.

  -Allow for voice messages to be left on answering machine and/or voice mail.

  -Allow for prior medical history and prescription records to be accessed and reviewed.

May we discuss your medical condition with another person?	Yes	No
If YES, please name the person(s) allowed		

Signature of Patient/Responsible Party: ______________________________ Date: ______________

Printed Name: _________________________