Patient Registration - Please print clearly

Name [Mr / Mrs / Dr / Ms / Miss]: _____
Date of birth: _____ **Social Security #** _____ - ____- _____

Address: _____
_____ _____-_____ *[zip]*

Cell Phone _____ **Home #** _____ **Work #** _____

Personal Primary Physician: _____
Physician who [if] referred you : _____
Date last seen by physician or / PA /Nurse: _____
Emergency contact information: _____

Insurance Information [bring insurance card(s) to visit, or copy of both sides]

Primary Insurance Plan Name (include all prefix and suffix letters)
_____

ID # _____ **Group number** _____**Other info** _____

Primary policy holder : complete the following if different than above patient (eg, patient is child insured via parents so parents complete below ; or patient is spouse or companion who does not have their own employment insurance so we need the insured spouses / companions demographic information)

Name: _____
Date of birth:_____ **Male / Female** _____
Occupation: _____ **Work phone** _____
Business Address: _____
Home Address: _____**Home/Cell#** _____

Secondary Insurance Plan Name (prefix and suffix letters)
_____

ID # _____ **Group number** _____

Secondary policy : complete the following if different than patient (eg, patient is child insured via two separate parent plans ; patient is spouse /companion who does have their own employment insurance but is also insured via other)

Name: _____
Date of birth:_____ **Male / Female** _____
Occupation: _____ **Work phone:** _____
Business Address: _____
Home Address: _____ **Home / Cell #s** _____

Consents and Agreements - Please read - print name and sign

* All office visit fees must be paid at the time of visit (if your insurance does not cover office visits, or if you have no insurance) including copays and deductibles. As a courtesy, we will submit x-rays, surgeries, and procedures to one insurance carrier if we are not a member of that panel or a participant. *If these submissions are not processed and paid within 60 days from the date of service, then all fees will become your responsibility.*

* Patients are responsible for all insurance plan referrals requirements, HMO requirements, out of network processes and other restrictions that may apply to their policies.

Please indicate if you are paying copays or non covered services today by _____ check _____cash

We do not process or accept Credit cards, Debit cards, or Health Savings Cards. We are willing to wait for you to process your online HAS check payments, when you return home, immediately after your visit.

Please initial each below and then complete all applicable signature line(s).

_____I give permission for evaluation and treatment of my condition. I will inform the office of any treatments or procedures that I do not desire, at any time, or while options of care are being discussed.

_____I / we acknowledge that I / we am personally financially responsible for those charges not totally covered by insurance. Any invoices not paid when due will be charged a service charge (minimum five dollars) and 1 & ½% interest per month (18% annually) and any direct costs (eg. Postage, certified fees).

_____I am aware that charges are made for missed appointments or those without twenty four hours notice of cancellation. An answering machine is available 24/7.

_____For past due accounts, managed via the Magisterial District Justice Courts, I / we am aware that the customer is also liable for all collection costs, including court costs, office processing costs, and attorney fees.

_____Known co-pays and non-covered insurance items are due at the time of service. Carrying fees occur if payments are delayed. If you do not have payment with you, we trust patients and send an invoice home with you to then remit payment.

Patient Signature & Printed name

Spouse Signature & Printed Name

_____ _____

Parent Signature & Printed name (if minor child / child insured via parent) or **POA** signature

_____

Primary Insurance Holder Signature: Example: Spouse's employer or business provides employee insurance and patient is family member using this plan but not paying for the plan

_____

Special Note for out of town parents: If you are giving permission for your child to use your insurance, and if you want to be directly billed and responsible for co-payments, deductible charges and any other costs, please additionally sign here and provide both parent names, addresses, phone numbers and any other information.

Please contact your insurance provider to understand your Cost-Sharing for office services which may include the following:

Co-Pays - A fixed payment set by the insurance carrier, and often noted on your card (so you know in advance your minimum payment obligation) due a the time of each office visit. This is a "Specialist" office, so if more than one co-pay is listed, look for SP and the amount.

Co-Insurance - Often in addition to a co-pay, it is a percentage of an approved and covered service (not all services are covered), often starting After you Deductible is met. For example, your insurance begins paying 80% (you pay 20%) or insurance pays 90% (you pay 10%).

Deductible - The Out-Of-Pocket patients have agreed, via their insurance contract, to pay physicians before your benefits kick in. Generally, lower premiums mean higher deductibles, and vice versa (perhaps like your car insurance or home owners insurance if applicable).

Dr Larry Assalita - Podiatric Patient History

Please fill out separate sports medicine history form if appropriate

Please note: Do not hesitate to provide any length of a summary or narrative of your entire history as related to your feet. You live with the problem 24 hours a day, and you may have insight, or information, that may make treatment more successful. There are no right or wrong answers - just answer with your first impression.

Indicate Right Foot, Left Foot, or Both here → _____ or indicate R / L / B in each question if varies

Primary Purpose of appointment :

Secondary Concerns:

What do you think the problem is ?

How long have you noticed the problem (s) ?:

Has it changed ?

Previous physician care ?

What have you tried ?

What makes it better / What makes it worse ?

How did you select / hear about this office ?

Is there anything you want us to know about you, your circumstances, family , work or other history ?

Activity and standing at work:
Activity and standing at home:

Height: _____ **Weight** _____ [has it increased or decreased] _____

Shoe size / brands / styles (**s**)
_____
Has size changed _____ When don't you wear shoes ?
_____
Are there dress code or other shoe wear requirements:

Alcohol : (how many years and amount / day / wk and type) _____
Smoking use: per day / how many years & what do you smoke **:** _____

If you no longer smoke, when did you quit ? _____
Recreational or other substance use _____

List **ALLERGIES** and type of reaction you have to any medication, materials or products :
_____

Don't forget to include aspirin, iodine, local anesthetic, latex, , adhesives, soaps, fabrics, and non prescription products
_____


Medical History


List medications: include vitamins, recreational drugs, birth control , smoking cessation, diet pills, supplements , eye drops List the name [generic or brand]; purpose ; strength ; times a day ; when started ; and who provides the Rx for you If you have a legible list to photocopy for your chart , you do not need to separately complete this section. Use the back of this form if necessary.

1.
2.
3.
4.
5.
6.

List FOOT surgery or foot care: include physician ; facility ;date ; original problems ; satisfaction of the results, any complications or problems .If you are coming here as an alternative opinion, or other care related to this, possibly bring records .

1.
2.
3.

List other surgery : Leg, hip, knee, and back are more important in details (particularly if you are having foot pain, numbness).

Identify anything where complications or problems or less than desirable outcomes occurred

1. 2.
3. 4.
5. 6.

Do you currently have , or did you in the past have, any symptoms, medical or other care for any of the following ?
And in the space below or on the reverse list any important details not already referenced in the rest of this registration . When possible, if you have any current general medical care, have your primary physicians office fax us your most recent office visit notes.

Musculoskeletal : back pain / arthritis / neck pain / ulcers / sciatica / joint implants / sprains / fractures

Skin: warts / ingrown nails / heat or cold sensitivity / athletes foot / cancer / tattoos / piercing

Cardiovascular: anemia / abnormal bleeding / heart problems / CVA / murmur / pacemaker / bypass legs

Urinary & Reproductive issues: prostate / hysterectomy / HIV / infections / ED / VD / kidney / gout

Central organs: stomach ulcers,/ bowel,/ diabetes / liver problems / hepatitis/ appendix / gout /

Head /Neck : dental surgery / cataracts / contacts / glaucoma / hearing loss / hearing aid / asthma / thyroid

Neurological : seizure / neuropathy / ADHD / depression / psychiatric / memory issues / stroke

Miscellaneous

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if so chose) ;Or may view it and print it at www.DrAssalita.com and understood the notice.

PLEASE COMPLETE THE FOLLOWING (those on web , print out this and other forms and bring to your office appointment)

PRINTED NAME :

_____

Printed name and relationship of Parent or authorized Representative :

_____

Signature: _____ **DATE:**_____

Note: please indicate who you authorize hear,  see,  , talk  Or otherwise communicate about you and release your records information to at this time ; and their status to you. You do not need to indicate anyone. However, please note, if for example, you have a spouse or companion, and they want to inquire on your behalf about anything (including your bills etc), if you do not list them, we cannot communicate with them until we would then get your permission. You may want to consider also listing a spouse , if you are here with your child. Or adult children, if you are elderly / live alone.

NAME:_____
STATUS:_____

NAME:_____
STATUS:_____

NAME:_____
STATUS:_____

NAME:_____
STATUS:_____

NOTE :  We can communicate about medical issues directly to other physicians ,  but it is also nice to list them here, if you want copies of y our consultation or other notes to go to them . Please add addition information as needed. Thanks.

DR ASSALITA'S PHYSICAN QUALITY REPORTING SYSTEM
ELECTRONIC HEALTH RECORDS DEMOGRAPHICS & PREFERENCES
FOR NEW PATIENTS AND UPDATING PATIENTS

Name:_____ Date Of Birth: _____

Race: _____ ( ) I prefer not to answer ( ) I do not know
(white, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, Etc)

Ethnicity: _____ ( ) I prefer not to answer ( ) I do not know

Preferred Language: _____ ( ) I prefer not to answer

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

PQRS is a reporting program to promote reporting of quality information by eligible professionals (EP's) for Services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Dr. Assalita's office participates in this program.

Have you had your flu shot for this season: ( ) Received for this season ( ) Recommended ( ) Unknown
Have you had your pneumococcal Vaccination: ( ) Yes ( ) No
Have you had any falls in the last 12 months: ( ) Yes ( ) No
How many? _____ Did any require treatment? _____
Do you have a living will? ( ) Yes ( ) No

PRIVACY INFORMATION PREFERENCES

Did you receive a copy of the HIPAA Privacy Practice Notice? ( ) Yes ( ) No
(or viewing this online?) ( ) Yes ( ) No
Would you like your information to be confidential within our Office and not included when the government requires us to file statistical reports on our patients? ( ) Yes ( ) No
Can we send mail to the address on file: ( ) Yes ( ) No
Can we call the phone number on file? ( ) Yes ( ) No
Can we leave voicemail on answering machine? ( ) Yes ( ) No
Will you allow internet based delivery reminders like email? ( ) Yes ( ) No
Email address_____
Who may we leave message with? ( ) Wife ( ) Husband ( ) Daughter ( ) Son ( ) Other

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SMOKING STATUS

( ) Current Every Day Smoker
( ) Current Some Day Smoker
( ) Former Smoker Quit: _____
( ) Never Smoker
( ) I decline to answer

VITAL SIGNS: What is your…

Blood Pressure: _____/_____
Height:_____
Weight: _____
( ) I prefer not to answer ( ) I do not know

Review of allergies: _____

Date Completing This Form:_____

Print & Sign name please:_____