PODIATRIC REGISTRATION AND HISTORY
Dr. Peter F. Gregory, D.P.M.

Patient's Name: _____ Date: ____/____/_____

Address: _____
City State Zip

Date of Birth: _____/_____/_____ Sex: ___Male ___Female

☐ Home Phone: _____ ☐ Cell Phone: _____
☐ Business Phone: _____ ☐ Email: _____
(Please *check* preferred method of contact above)

SS#: _____

Marital Status_____ Spouses name if applicable_____

Employer: _____ Occupation: _____
Employers Address: _____

(We are now required to ASK the following three questions on ethnicity and race by the U.S. Government. You may decline to answer if you wish)

1) Ethnicity: ___Hispanic or Latino ___NOT Hispanic or Latino ___Unknown ___Declined

2) Race: ___Asian ___Black / African American ___Native Hawaiian / other Pacific Islander
___White ___Other race ___Unknown ___Declined

3) Language spoken at home: _____ ___Declined

Whom may we thank for referring you? _____

What is the main problem with your feet or ankles? _____

_____

Is this an injury? _____ When did you first notice it? _____

Please indicate which foot problems you now have:

___Ankle Pain	___Athlete's foot	___Bunions
___Corns / Calluses	___Cramps	___Flat Feet
___Fungus Toenails	___Heel Pain	___Ingrown Toenails
___Numbness in feet legs	___Plantar Warts	___Swelling in ankles / feet

PODIATRIC REGISTRATION AND HISTORY
--2--

INSURANCE

Who is responsible for this account? _____
Relationship to Patient? _____
Insurance Company: _____
ID # : _____ Group # : _____
Secondary Insurance Company (if any): _____
ID # : _____ Group # : _____
Subscriber's name _____
Subscriber's date of birth: _____

Insurance Assignment and Release

I certify that I have insurance coverage with the Insurance Company(ies) identified above and assign directly to Dr. Peter F. Gregory, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named Doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare / Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made to Dr. Peter F. Gregory, D.P.M. for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____
Date Relationship to Beneficiary

PODIATRIC REGISTRATION AND HISTORY

--3--

Height: _____ Weight: _____ Shoe size: _____

MEDICAL HISTORY (please check any problems you have had)

___AIDS	___Anemia	___Arthritis	___Asthma
___Bleeding Problems	___Bursitis	___Cancer: (type)_____	
___Colitis/Crohn's	___COPD	___Epilepsy	___Fibromyalgia
___Glaucoma	___Gout	___Heartburn	___Heart Problems
___Hepatitis	___High blood pressure	___High Cholesterol	___Joint Implants
___Kidney Problems	___Leg Cramps	___Lung Disease	___Mental Health
___Nerve Conditions	___Osteoporosis	___Poor Circulation	___Rheumatic Fever
___STD's	___Sickle Cell	___Skin Disorders	___Stomach Ulcers
___Stroke	___TB	___Thyroid Disease	___Tumors
___Varicose Veins			

___Diabetes: If checked what are:

The name, phone number and address of the doctor treating you for the diabetes:
Doctor's Name:_____
Phone Number:_____
Address: _____

When did you last see this doctor?_____
What is your average blood sugar reading?_____
What is your most recent hemoglobin A1C_____

SURGICAL HISTORY

Procedure_____ Date_____
Procedure_____ Date_____
Procedure_____ Date_____
Procedure_____ Date_____
Procedure_____ Date_____

Hospitalizations other than for the surgeries listed above_____
_____

Did you ever have any injuries to your legs / ankles / feet?_____

Are you pregnant?_____ How many months? _____

Family Physician: _____

PODIATRIC REGISTRATION AND HISTORY

--4--

SOCIAL HISTORY

___I smoke ___packs everyday ___ I smoke on *some* days
___I *used* to smoke ___I *neve*r smoked
___Smoker but current status unknown ___Unknown if ever smoked

I consume alcohol: ___Never ___Rarely ___Occasionally (not every day) ___Everyday

MEDICATIONS **Pharmacy: _____**
Phone Number ---------- _____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES (please check all that apply)

___NONE ___Aspirin ___Adhesive / Tape ___Codeine
___Cortisone ___Demerol ___Iodine ___Latex
___Local Anesthetics (e.g.: Novocain) ___Penicillin ___Sulfa
___OTHER (please specify) _____

FAMILY HISTORY (has any family member every had):

DIABETES	___Father	___Mother	___Sister	___Brother
HEART DISEASE	___Father	___Mother	___Sister	___Brother
HIGH BLOOD PRESSURE	___Father	___Mother	___Sister	___Brother
ARTHRITIS	___Father	___Mother	___Sister	___Brother
GOUT	___Father	___Mother	___Sister	___Brother
OTHER_____	___Father	___Mother	___Sister	___Brother

TREATMENT CONSENT / PRIVACY PRACTICES

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary. Further, 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 I so chose) and understand the notice.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PRIVACY POLICY
DR. PETER F. GREGORY, D.P.M.

We will only use and disclose your health information for the following purposes:
To treat you, to assist other healthcare providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the **Notice of Privacy Practices**, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual **Notice of Privacy Practices** provided to you for the person(s) whom you may contact.

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the person(s) indicated below.

Please circle your choice(s) below:

Any member of my immediate family	Yes	No
Spouse only	Yes	No
Other (please specify)_____	Yes	No

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature_____ Date_____

Patient Name of Authorized Representative (Please Print)_____

Dr. Peter F. Gregory, D.P.M
Financial Policy

Thank You for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

Please read our Financial Policy and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policy:

INSURANCE: If you provide us with your insurance information, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company, therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. Please inform us of any changes in your insurance coverage and be prepared to show your insurance card at each visit.

NO INSURANCE: If you do not have insurance or the proper referral required by your insurance, please be prepared to fully cover the fees for each visit at the time of treatment, unless other arrangements have been made.

PAYMENT: Please pay co-payments at the time of your visit. We accept cast, check, Visa, MasterCard or Discover credit card payments. An extended payment plan you be arranged to make monthly payments if desired by contacting our billing manager. There will be a $25.00 charge for returned checks that will be added to your balance. Delinquent accounts will be referred for collection at the discretion of the office manager.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the treatment and charges. Young adults (age 18 and over) are legally responsible for their accounts unless a parent (or guardian) accompanies them to the initial appointment and signs the Financial Policy, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your benefits. A deposit of $250.00 is requested at the time of examination and casting.

REFERRALS: If your insurance plan requires you to have a referral from your primary care physician prior to obtaining the services of a specialist, those services may not be covered (or will be reimbursed at a lower rate) unless a referral form has been provided by your primary care doctor. You have the right, of course, to choose the services without the referral. However you will be held financially responsible for these services.

I have read and agree to the terms set fourth in the above financial policy.

Signature: _____ Date: _____