

# WELCOME TO OUR OFFICE

Name \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_  
*Last Name First Name Middle Name*

Home Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Sex:  Male  Female      Marital Status:  Single  Married  Widowed  Partner

Date of Birth \_\_\_\_\_ Email Address \_\_\_\_\_ Student:  Fulltime  Part-time

Employer \_\_\_\_\_ How long? \_\_\_\_\_

Employer Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Work phone \_\_\_\_\_ Ext \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Address/Phone \_\_\_\_\_

Family Physician Date Last Seen \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_ Co-pay amount (Specialist) \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Insurance company's phone \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_

Insured Employer \_\_\_\_\_ Employer's phone \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Co-pay amount (Specialist) \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Insurance company's phone \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_

Insured Employer \_\_\_\_\_ Employer's phone \_\_\_\_\_

I hereby authorize Associated Family Foot Care Centers to submit a claim to my insurance carrier for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to the physician rendering the covered service. I will be responsible for those charges deemed not covered by said insurance carrier so long as such insurance has not deemed such services to be medically inappropriate or unnecessary. I also understand that if my insurance company is not a contracted carrier, I am responsible for the full fee charged by my physician regardless of what my insurance pays. I authorize AFFCC to furnish complete information to my insurance carrier and its intermediaries regarding the serviced rendered. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
Responsible party's signature

\_\_\_\_\_  
Date

# GENERAL HEALTH

NAME \_\_\_\_\_

DATE \_\_\_\_\_

1. What are your present foot problems? How long? \_\_\_\_\_

2. Do you have/or have you ever had any of the following? Please check yes or no.

	Yes	No	Family		Yes	No	Family
Anemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MSRA Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis – Type __	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DVT (Blood clot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please list any operations you have had. \_\_\_\_\_

4. Please list all prescription and non-prescription medications you are currently taking. \_\_\_\_\_

5. Are you allergic to any of the following? If yes, please list drug names by category.

LATEX: YES or NO

Antibiotics: \_\_\_\_\_

Pain Medication: \_\_\_\_\_

Other: \_\_\_\_\_

6. Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

7. Women Only: Is there any possibility you could be pregnant? YES or NO  
Date of last menstrual period? \_\_\_\_\_

8. Social History: Do you smoke? Yes or No How many packs a day? \_\_\_\_\_ Quit, when? \_\_\_\_\_

Please indicate how much alcohol you consume:

None: \_\_\_\_\_

Glass of wine per week: \_\_\_\_\_

Beers per week: \_\_\_\_\_

Glass of liquor per week: \_\_\_\_\_

**ASSOCIATED FAMILY FOOT CARE CENTERS  
DR. BRIAN A. NAGY**

**PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL  
PRIVACY NOTICE & FINANCIAL RESPONSIBILITY**

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**Consent for care:** I, with my signature, authorize AFFCC, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

**Consent for release of information:** I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

**Consent for assignment of benefits :** I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any coinsurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. If for any reason my insurance plan does not pay for my approved charges in full, I agree to be fully responsible for the amount. I also agree, should collections be necessary for payment of my account, to be fully responsible for any collections fees and associated costs.

**Consent and acknowledgement of Medical Privacy Notice:** I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_ If not patient, relationship: \_\_\_\_\_