Podiatry Associates of Rochester, LLP

Patient Registration

Name (Last)_____(First)_____(MI)____

Home Address _____ Apt. #_____

City, State, Zip _____

Phone # Home _____ Work _____ Cell _____

SS # _____ Age ____ Date of Birth ____/____/_____ Sex M / F

Employer _____ FT/ PT/ Ret. Occupation _____

Primary Care Physician _____Last visit_____

Please list the Name, Phone # and Relationship of your emergency contact:

_____

Whom may we thank for referring you? _____

PRIMARY INSURANCE Co._____
ID # _____ Group # _____
Subscriber _____ Subscriber Date of Birth __/__/____
Relationship to patient _____

SECONDARY INSURANCE Co._____
ID # _____ Group # _____
Subscriber _____ Subscriber Date of Birth __/__/____
Relationship to patient _____

DO YOU HAVE AN INJURY RELATED TO: ____WORKERS COMP ____ NO FAULT

Date of injury ___/___/____ Type of injury ___work ___auto __other
Claim # _____ Cause of injury_____
Insurance Company Name_____
Insurance Company Address _____
Adjuster name/phone _____

RELEASE OF INFORMATION

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment due at time of service.)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient (guarantor) signature:_____Date:_____

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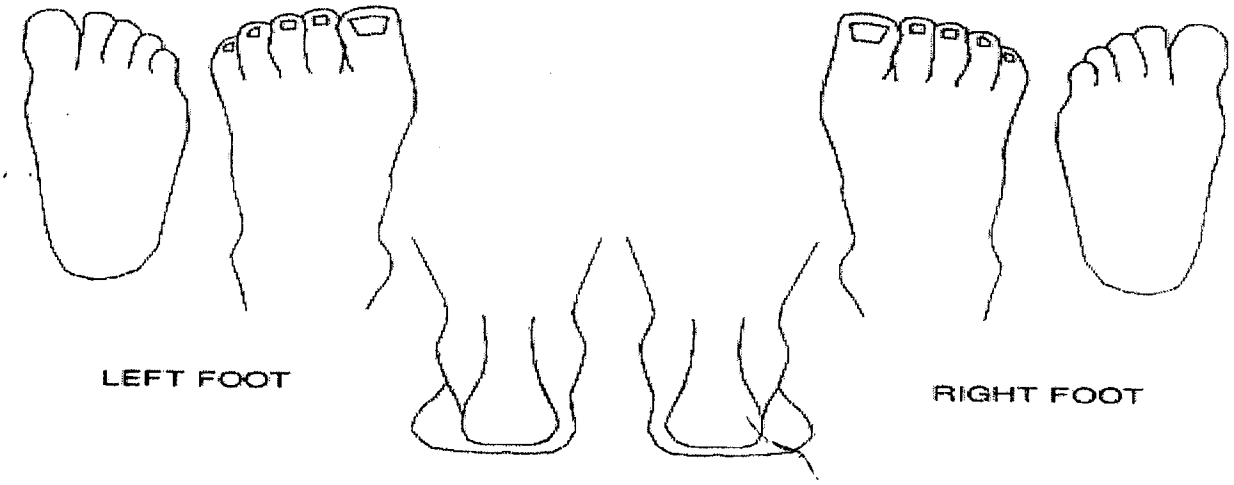
Ethnicity

Hispanic/Latino __ **Native American/Alaska Native __** **Asian __**
African American __ **Native Hawaiian/Other Pacific Islander __**
Caucasian __ **Other _____**

Height _____ Weight _____ Shoe Size _____

Location of Discomfort



Description of Discomfort

Burning __ **Tingling __** **Swelling __** **Numbness __**
Aching __ **Dull Pain __** **Sharp Pain __**
Other (Please Describe) _____

Allergies

Allergen	Type (Drug, Food, Environment)	Location (Rash, Hives, Etc.)	Severity (Mild, Moderate, Severe)

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Current Medication

Drug Name	Dosage	How Often Taken	Date Started

Surgical History

Year	Reason	Additional Information

Social Habits

Alcohol	Do you drink alcohol? Are you a Social Drinker? Are you an Alcoholic?	Yes __ Yes __ Yes __	No __ No __ No __
Tobacco	Do you use Tobacco Products? If so, which ones apply:	Yes __	No __

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	Cigarettes- # Packs/Day: _____	Yes __	No __
	Chew- How Often: _____	Yes __	No __
	Pipe- How Often: _____	Yes __	No __
	Cigars- How Often: _____	Yes __	No __
	Vape- How Often: _____	Yes __	No __
	How long have you used Tobacco Products? _____		
	If you used to smoke, how long since you've quit? _____		

Contact and Payment Authorization

May we have your permission to leave a message at your home?	Yes __	No __
May we have your permission to leave a message on your cell?	Yes __	No __
May we have your permission to leave a message at your work?	Yes __	No __
May we have your permission to leave a message with other members of your household?	Yes __	No __

I authorize Podiatry Associates of Rochester, LLP to treat my feet. I further authorize the release of medical information necessary for the completion of my Insurance forms. I authorize payment directly to Podiatry Associates of Rochester, LLP for all medical or surgical benefits otherwise payable to me under the terms of my Insurance. I understand that I am financially responsible for all co payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient/Gaurdian Signature _____ Date

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MEDICAL HISTORY

In the past month have you had?	Bronchitis	☐	Yes	☐	No
	Pneumonia	☐	Yes	☐	No
	Cold/Flu	☐	Yes	☐	No
Medications used to treat above (if applicable):					

Are you currently pregnant?	☐	Yes	☐	No
Have you been diagnosed with Sleep Apnea?	☐	Yes	☐	No
Have you been part of a sleep study?	☐	Yes	☐	No
Do you use a CPAP machine?	☐	Yes	☐	No
Do you use home oxygen?	☐	Yes	☐	No
Do you have high blood pressure/Hypertension?	☐	Yes	☐	No
Have you had a heart attack?	☐	Yes	☐	No
Have you had a Mitral valve prolapse?	☐	Yes	☐	No
Have you had any other heart murmur?	☐	Yes	☐	No
Are you seeing a cardiologist?	☐	Yes	☐	No
Are you undergoing any cardiac testing?	☐	Yes	☐	No
Do you use a pacemaker or defibrillator?	☐	Yes	☐	No
Can you walk one block or take a flight of stairs without stopping?	☐	Yes	☐	No

Hiatal Hernia?	☐	Yes	☐	No	Lower Back Pain?	☐	Yes	☐	No
High Cholesterol?	☐	Yes	☐	No	Physical Limitations?	☐	Yes	☐	No
Thyroid Disease? What type?	☐	Yes	☐	No	Arthritis?	☐	Yes	☐	No
Acid Reflux (GERD)?	☐	Yes	☐	No	Osteoarthritis?	☐	Yes	☐	No
Crohn's?	☐	Yes	☐	No	Rheumatoid?	☐	Yes	☐	No
Ulcers?	☐	Yes	☐	No	Fibromyalgia?	☐	Yes	☐	No
Liver Disease?	☐	Yes	☐	No	Lupus?	☐	Yes	☐	No
Hepatitis?	☐	Yes	☐	No	Epilepsy/Seizures?	☐	Yes	☐	No
Bleeding Problems? What type?	☐	Yes	☐	No	Stroke?	☐	Yes	☐	No
Diabetes Type I?	☐	Yes	☐	No	Mini-Stroke?	☐	Yes	☐	No
Diabetes Type II?	☐	Yes	☐	No	Depression?	☐	Yes	☐	No
Kidney Disease?	☐	Yes	☐	No	Anxiety?	☐	Yes	☐	No

Alzheimers/Dementia?	☐	Yes	☐	No
Developmental Delays?	☐	Yes	☐	No
A reaction to anesthetic?	☐	Yes	☐	No
Do you have any difficulty with anesthesia? Please explain:	☐	Yes	☐	No
Malignant hypothermia?	☐	Yes	☐	No
Sickle Cell anemia or trait?	☐	Yes	☐	No

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Of
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Robert Russo, DPM

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John Ellie, Jr., DPM

PAYMENT POLICY

Thank you for choosing us as your Podiatry Specialists. We are committed to providing you with quality and affordable health care. In order to streamline any questions you may have concerning insurance and payment options, we've addressed several topics below.

1. INSURANCE. We participate in most insurance plans. We must have a copy of your insurance card in your chart. Please inform us of any changes to your coverage.

2. CO-PAYMENTS AND DEDUCTIBLES. All co-payments must be paid at the time of your visit. A $10.00 billing fee will be added in the event of non-payment. Deductible balances will be billed to you and payment is due in 30 days of receipt.

** MEDICAID DOES NOT COVER CO-PAYMENTS FOR PODIATRY**

3. CLAIMS SUBMISSION. We will submit your claims and assist you an any way we reasonably can to help get your claims paid. Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Payment will be expected in these instances. Any balance remaining after insurance payment is received is your responsibility.

4. QUESTIONS. Please contact our billing department with questions about your account. We are happy to set up payment plans where needed. Please call Nancy Curran at 585-227-0206.

I have read and understand the payment policy and agree to abide by its guidelines:

_____/_____
signature of patient or responsible party date