MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

Patient Registration Form

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ SS#: _____ Sex: M or F Marital Status: Single/Married/Widowed

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a confidential message on your answering machine? Yes or No

Email Address: _____

Race: _____ Hispanic or Non-Hispanic Primary Language: _____

Employer: _____ Occupation: _____

Emergency/Alternate Contact: Please list any additional people you authorize us to speak with regarding your health/appointments.

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

How did you hear about our office?

- ☐ Patient Referral: _____
- ☐ Doctor Referral: _____
- ☐ Facebook
- ☐ Google
- ☐ Radio
- ☐ Digital Ad
- ☐ Other: _____

Insurance Information:

Primary Insurance:

_____

Secondary Insurance:

_____

Subscriber of Insurance:

_____

DOB of Subscriber:

_____

Phone Number of Subscriber:

_____

Relationship to Subscriber:

_____

Do you have HSA or FSA?

_____

Guarantor Information:

(Person who holds financial responsibility for patient statements)

Guarantor Name:

_____

Guarantor address:

_____

Guarantor Phone Number:

_____

Guarantor DOB:

_____

Work Related Injury:

Is your visit today associated with a work related injury? Yes or No

Date of Injury:

_____

Claim Number:

_____

Claim Adjuster Name:

_____

Phone:

_____

Email:

_____

Workers Comp Carrier:

_____

Milwaukee Foot and Ankle Specialists will bill your insurance company on your behalf for your services. I authorize my insurance benefits to be paid directly to Milwaukee Foot and Ankle Specialists. I understand that I am financially responsible for my balance. I also authorize Milwaukee Foot and Ankle Specialists and/or insurance company to release any information required to process my claims. This agreement will remain in effect until revoked by myself in writing. A copy of this document is considered valid as the original. The above information is true to the best of my knowledge. I will notify Milwaukee Foot and Ankle Specialists of any changes.

Patient or Guardian Signature: _____ Date: _____

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Patient Medical History:

PrimaryCarePhysician:_____ Phone:_____ DateLastSeen:_____

Pharmacy: _____ Location/Cross Streets: _____

What are you being seen for today? _____ When did your condition begin? _____

Please rate your pain on a scale of 0-10 (10 being the worst pain you can imagine) 0 1 2 3 4 5 6 7 8 9 10

Is this a work related injury? Yes OR No If yes, please give the date of injury: _____

Height: _____ Weight: _____ Shoe Size: _____

Hobbies: _____

Do you smoke? Yes OR No How many packs per day? _____ How many years? _____

Do you drink alcohol? Yes OR No How frequently? Rarely Socially Daily

Do you exercise? Yes OR No Type of activity: _____ Frequency: _____

Are you diabetic? Yes OR No If yes, do you take insulin? Yes OR No

Have you ever been treated for any of the following conditions? (Check all that apply)

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Liver problems
- ☐ Pacemaker
- ☐ Blood clots
- ☐ HIV
- ☐ Heart trouble
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Hepatitis C
- ☐ Stroke
- ☐ Asthma

Family Medical History:

- ☐ Diabetes
- ☐ Cancer
- ☐ Blood clots
- ☐ Stroke
- ☐ Asthma

Significant Past Medical History (please list):

_____

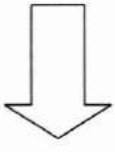
Please list ALL medications you are currently taking or attach medication list:

_____

Please list ANY allergies to ANY medications: _____

Please list ANY major surgeries (within the last 10 years): _____

PLEASE SEE REVERSE SIDE OF THIS PAGE



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Review of Symptoms:

General:
- ☐ Unexpected weight loss/gain
- ☐ Fevers
- ☐ Chills
- ☐ Fatigue

Eyes:
- ☐ Corrective lenses
- ☐ Blurred/double vision
- ☐ Eye pain
- ☐ Redness
- ☐ Watering

ENT:
- ☐ Headaches
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Earaches

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Murmurs
- ☐ Poor circulation
- ☐ Cold feet
- ☐ Calf pain

Respiratory:
- ☐ Shortness of breath
- ☐ Sneezing
- ☐ Coughing
- ☐ Chest tightness
- ☐ Chest pain
- ☐ Snoring

Gastrointestinal:
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Bleeding
- ☐ Colitis
- ☐ Crohn's
- ☐ Ulcers

Genitourinary:
- ☐ Renal failure
- ☐ Difficult urination
- ☐ Flank pain
- ☐ Kidney stones

Musculoskeletal:
- ☐ RA
- ☐ Lupus
- ☐ Gout
- ☐ Joint pain
- ☐ Swelling
- ☐ Instability
- ☐ Stiffness
- ☐ Redness
- ☐ Deep muscle pain

Skin:
- ☐ Unusual changes
- ☐ Poor health
- ☐ Rash
- ☐ Itching
- ☐ Redness
- ☐ Ulcerations
- ☐ Infections

Neurologic:
- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizure
- ☐ Stroke
- ☐ Weakness
- ☐ Drop foot

Psychiatric:
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Hematologic:
- ☐ Easy bleeding
- ☐ Bruising
- ☐ Cancer
- ☐ Coumadin
- ☐ Blood thinners

Endocrine:
- ☐ Excessive thirst or urination
- ☐ Heat/cold intolerable
- ☐ Thyroid (high or low)

Doctor Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF HIPAA POLICY

Milwaukee Foot & Ankle Specialists provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Milwaukee Foot & Ankle Specialists or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For medical treatment & referral
- To obtain payment & file insurance
- In emergency situations
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes
- For research and education
- To prevent serious threats to health safety
- For appointment and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to paper copy of this notice
- The right to request confidential communications
- The right to request restrictions

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Milwaukee Foot & Ankle Specialists may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for care by the doctors and staff of Milwaukee Foot & Ankle Specialists. You hereby grant full authority to the Podiatrists and their respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to or upon your person, which may be advised or necessary.

Effective Date

This notice is in effect as of April 15, 2003.

Patient Acknowledgement

By signing below, I acknowledge receipt of a copy of this notice.
I have full understanding and am in agreement to its terms.

Patient or Guardian Signature:_____ Date:_____

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FINANCIAL AND CANCELLATION POLICY

We are pleased to offer you the service of billing your insurance company for the care you have received from our doctors. It is your responsibility to notify us of any changes in your insurance coverage.

If you are uninsured, payment is due in full on the date of service, or payment must be made in advance. For insured patients, co-pays and deductibles are due on the date of service provided to you in the office.

The fees we charge for services are usual and customary for this area. Your health insurance policy may base its allowances on a fixed fee schedule that may or may not coincide with our usual fees. You should be aware that different companies may vary greatly in the type of coverage available.

Ultimate responsibility of payment for services rendered is yours.

For our Medicare patients, we agree to accept the charge determination of the Medicare carrier as the full charge. You are responsible only for the deductible, coinsurance, and non-covered services as determined by the Medicare carrier.

I hereby authorize Milwaukee Foot and Ankle Specialists to release to any insurance company, physician, or hospital all medical information which is necessary to afford proper treatment or obtain payment for services. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I have read and fully understand the above, and I realize that I am responsible for any charges not covered by my insurance.

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments below:

A MISSED APPOINTMENT IS WHEN YOU FAIL TO SHOW UP FOR AN ALLOTTED APPOINTMENT TIME, WITHOUT A PHONE CALL OR CANCELLATION NOTICE OF (AT LEAST) 24 HOURS.

A $50 fee will be assessed for each appointment that fails to comply with the above policy.

Patient or Guardian Signature:_____ Date:_____