DR. GARY SCHEININ DPM

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Legal name: First Middle Last

Street address City State Zip code

If referred by someone, please write name here so we can thank them:

Occupation / Employer:			**Preferred Name:**	**Marital Status** (circle one) Single / Mar / Div / Sep / Wid
Date of Birth / /	**Age:**	**Gender (Circle One)** Male Female	**Social Security Number**	

I heard about Our office from:

❑ Doctor ❑ Insurance ❑ Hospital ❑ Family ❑ Friend ❑Drive-by ❑ Yellow Pages ❑ Other___________________

Email:	**Phone numbers:** Cell: Home: Work:
Race (circle one): White Asian Black/AfricanAmerican Multi-Race Pacific Islander American Indian /Alaska Native Native Hawaiian Refuse to Report	
Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Refuse to Report	

RESPONSIBLE PARTY AND INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone Number:

Relationship to patient:

Is patient covered by insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Gary Scheinin or insurance company to release any information required to process my claims.

Patient/ Responsible Party signature

Date

Patient Name________________________________ **Preferred Pharmacy**_________________________________

Podiatric History

What problem are we seeing you for today?____

How long have you noticed this problem?____________________Approximate Date of Injury?____________________

List previous treatments for this problem:____

Have you ever seen a Podiatrist before? Y N For what problem? ____

Medical History

Major Surgeries/ Hospitalizations you have had (w/dates):____

____

Are you currently pregnant or Nursing? ☐ Yes ☐ No How many Pregnancies? _______ How many deliveries?______

Diabetic Patient: Diagnosed: ________ HgA1c: _____ Date: ________ Home Glucose – Fasting ________ Date________

Primary Care Doctor____ Date Last Seen ___________

Height_______ Weight_________ Do you Smoke? Packs per day:_______________

Age_________ Shoe Size________ Do you drink Alcohol? How often?___________

Review of Systems: If you have problems with any of the following health conditions, please circle them.

Anemia	Dementia or Memory Loss	High blood pressure	Stroke
Arthritis	Depression	High cholesterol	Swelling in ankles/feet
Artificial Joints	Diabetes(Type I/ Type II)	Infection (currently)	Thyroid problems
Asthma	Eye problems	Kidney problems	Tuberculosis
Back problems	Fibromyalgia	Liver Disease	Ulcers (stomach)
Bleeding Disorders	Foot/leg cramps	MS	Ulcers (leg/foot)
Cancer	Gout	Neuropathy Phlebitis	Varicose veins
Chest Pain	Heart Disease	Psychiatric Care	Other:_____________
Circulatory Problems	Hepatitis/Jaundice	Respiratory Disease	__________________

Medications Include prescriptions, over-the-counter		
Name	Dosage/Strength (i.e. 20mg)	How often do you take this?

Allergies? Yes or No	
Allergies	**Reaction**

Family History

Hypertension	Father	Mother	Siblings	Children	Grandfather	Grandmother
Stroke	Father	Mother	Siblings	Children	Grandfather	Grandmother
Cancer	Father	Mother	Siblings	Children	Grandfather	Grandmother
Diabetes	Father	Mother	Siblings	Children	Grandfather	Grandmother
Kidneys	Father	Mother	Siblings	Children	Grandfather	Grandmother
Other________	Father	Mother	Siblings	Children	Grandfather	Grandmother

Immunization

Tetanus _____________ Flu/ H1N___________ Pneumonia_____________ HEP B/HEP C___________

Policies and Procedures Agreement

HIPAA PRIVACY POLICY

I have received or been offered a copy of Gary S Scheinin, DPM's Notice of Privacy Practices. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

MEDICAL TREATMENT POLICIES

XRAYS: I understand that X-ray originals are owned by the doctor as they are a part of the medical record. I may receive a digital copy at my request.

TREATMENT: I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor or staff.

ASSIGNMENT AND RELEASE: I authorize the doctor to retrieve a list of my current medications in order to check for any possible interactions with my treatment and / or medical records as needed from laboratories, radiology facilities and other physicians.

INSURANCE GUIDELINES

I understand that my insurance policy is a contract between myself and my insurance carrier. The medical office is a third party that bills the insurance as a courtesy to me. Due to the large number of different insurance companies and their frequent changes, it is very difficult to keep track of each insurance plan's ever-changing benefits and rules. While the medical staff will do their best to assist with insurance matters, I understand that it is ultimately my responsibility to know what my insurance covers. The doctor will assess and offer treatment based on the best medical options available, but if I have a question about coverage I have the responsibility to contact the insurance before accepting treatment.

It is my responsibility to understand the terms of my contract with my insurance company in regard to copays, deductibles, and benefit amounts. Copays and deductibles will be collected at the time of service from the medical office. If my insurance company is delinquent on paying for my treatment, the medical office may request payment from me and will refund me once the insurance pays. If my insurance requires a referral it is my responsibility to obtain that before date of service.

FINANCIAL AGREEMENT

Missed appointments and same-day cancellations may be subject to a $50.00 charge. Because my appointment time is reserved specifically for me, it is my responsibility to give 24 hours' notice if I will not be able to keep my appointment.

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. If I am unable to pay the full balance on my account, I will make payments each month toward the balance until it is paid off. If no payment is received within 30 days my account will accrue interest at a rate of 1.5% of the remaining principal balance each month. Any balance that has no payment made for 90 days will be sent to a debt collections agency. The medical office will attempt to contact me both by phone and mail before this happens. In the event the account is turned over to Collections, I understand that I am responsible for all court costs. The terms of this agreement apply to any present or future expenses incurred by me or by any individual for whom I have financial responsibility.

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Patient/Responsible Party Signature *Date*