

Welcome to the office of:

Affiliated Footcare Center
Podiatric Medicine & Surgery

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____ Sex: M F _____
Last Name _____ First Name _____ Middle Initial _____ Mr. _____ Mrs. _____ Sng _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
In case of Emergency _____ RELATIONSHIP _____ Phone _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who referred you to our office? _____
Primary Care Physician _____ Phone # _____
Address _____ Phone# _____ Fax # _____
May we contact your physician about your health? Yes ___ No ___ Date you last saw your doctor _____
Pharmacy Name _____ Phone # _____
Do you take Coumadin Aspirin other _____ yes No How Long _____

PRIMARY INSURANCE (ALL FIELDS MUST BE FILLED IN)

Person Responsible for Account _____ SOC. SEC. # _____
RELATIONSHIP TO PATIENT _____ BIRTHDATE _____
Address _____ Home Phone _____
City _____ State _____ Zip Code _____
Employed By _____ Business Phone _____
Insurance Company _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured name _____ SOC. SEC. # _____ BIRTHDATE _____
RELATIONSHIP TO PATIENT _____ Home Phone # _____
Address _____ City _____ State _____ Zip Code _____
Insured Employed by _____ Business Phone _____
Insurance Company _____

REASON FOR TODAY'S VISIT PLEASE INDICATE THE PROBLEM THAT BROUGHT YOU TO THE OFFICE

What is your main foot problem today & are there others you would like to discuss? _____
Explain: _____
When did your main problem begin? _____ Location of problem area _____
Is the pain: Burning Throbbing Sharp Dull Aching Other? _____
What causes the problem or makes it worse? _____
Was it caused by an injury? Yes ___ No ___ (explain if yes) _____
Does anything else affect the problem? Yes ___ No ___ (explain if yes) _____
Are there any associated signs or symptoms? Yes ___ No ___ (explain if yes) _____
Shoe Size _____ Current Weight _____ Height _____ Do you wear orthotics? _____

GENERAL HEALTH INFORMATION & FAMILY HISTORY

Do you have Diabetes? Yes ___ No ___ If yes, do you take insulin? Yes ___ No ___ Number of years _____

Have you had any serious illnesses, major injuries, or any major surgeries (if yes explain on back)? Yes _____ No _____

Are you under a physician's care? Yes ___ No ___ If yes, for what condition _____

What medications do you take regularly? _____

Is there a Family History of any of these disorders:

Tuberculosis Epilepsy Gout Hypertension Heart Attack Kidney disease Diabetes
 Allergies Cancer Spinal disorder Mental illness Arthritis Migraines Other _____

Immunizations: Measles Mumps Polio Tetanus Typhoid Flu Pneumonia TB

REVIEW OF SYSTEMS (ROS) PLACE AN X IN THE BOXES THAT APPLY TO YOU

Do you have: Arthritis Joint Disease Muscle Pain Stiffness Bursitis Lumbago
 Sciatica Club foot Fractures Sprains Other _____

Gastrointestinal Problems, If yes explain: _____

Do you have: Poor appetite Stomach Trouble Ulcers Liver trouble Other explain _____

Nervous system Problems, If yes explain: _____

Numbness Dizziness Muscle Jerking Confusion Stroke Seizure Loss of Feeling Fainting Convulsion
 Depression Weakness Brain disease Paralysis Headaches Forgetfulness Spine disease Other _____

Do you wear glasses? _____

Eye Strain Eye disease Eye Inflammation Eye injury Vision problem Impaired sight

Cardiovascular/Heart problems, if yes explain: _____

Chest Pain Heart attack Rapid heartbeat Night sweats Hands swell Pain over heart High blood press.
 Tiredness Varicose veins Feet swell Leg pain on walking Weakness Other _____

Respiratory problems, if yes explain: _____

Persistent cough Lung problems Coughing phlegm Wheezing Difficult breathing Coughing blood
 Asthma Bronchitis Emphysema Shortness of breath Hay fever other _____

Skin Rashes and conditions, if yes explain: _____

Itching Skin rash Moles Deformed nails Eczema Psoriasis Abrasions
 discoloration's Birth marks Hives Bruises Ulceration's Skin cancers Other _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. GORDON FOSDICK all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have also read and been told the privacy policies provided by the office staff under the HIPPA law that states my personal information will not be given to anyone without my consent.

THIS OFFICE PROMISES NOT TO TELL A "SOLE" ABOUT YOUR FEET! A written copy is mine to keep if I choose to do so.

THIS OFFICE ALSO HAS A NO SHOW POLICY PLEASE GIVE A 24 HOUR NOTICE IF YOU CAN NOT MAKE AN APPOINTMENT OR YOU WILL BE CHARGED A \$50.00 FEE. A 2% FEE WILL APPLY TO OUTSTANDING BILLS AFTER 30 DAYS. PLEASE TAKE NOTE. EMERGENCIES ARE AN EXCEPTION.

Signature of Responsible Party _____ Date _____

AFFILIATED FOOT CARE CENTER, LLC

Gordon E. Fosdick, DPM

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Board Certified in Foot Surgery*

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(860) 349.3081 fax

Wallingford Office
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Wallingford, CT 06492
(203) 294.4977
(203) 294.0045 fax

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices (the "Notice") is available for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. Uses and Disclosures of Your Health Information: We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcription service, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
2. Other Uses and Disclosures: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. Your Health Information Rights: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
 - a. You may request restrictions on certain uses and disclosures of your information
 - b. You may request that you receive your information from us in a certain way
 - c. You may inspect and copy your medical records
 - d. You may request an amendment to any record you believe is inaccurate
 - e. You may request an accounting of disclosures made of your records
4. Changes to the Notice: we reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.
5. Complaints: you may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filling any complaint.

Policy has been made available to me for review.

Signature: _____

Soc. Sec.# _____

Name: _____

Date: _____