MARK N. LEVY, DPM
PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (circle one) M S D W
Street address:				
City:		State:		ZIP Code:
Home Phone #:	Work Phone #:		Cellular Phone #:	
Social Security #:	Employer:		DOB: / /	☐ M ☐ F

Ethnicity: Government required	☐ American Indian or Native Alaskan	☐ Asian	☐ African American Or Black	☐ Hawaiian Or Other Pacific Islands	☐ Caucasian	☐ Hispanic

Primary Care Physician:	Last Date Visited:	Your Email :
May we contact your physician about your health? ☐ Yes ☐ No	Referring Doctor:	
Name of Pharmacy:	Pharmacy Phone #:	

BILL RESPONSIBLITY INFORMATION

Person responsible for bill:		Relationship:
Street address:		Home Phone#:
City:	State:	ZIP Code:
Employer:	Position:	Work Phone #:

INSURANCE INFORMATION *(Please give your insurance cards to the receptionist.)*

Primary Insurance Information

Insured Insurance Company:		
Insured Name:		Relationship:
Insured Employer:		Insured Social Security #:
Policy#:	Group #:	Co-pay: $

Secondary Insurance Information

Insured Insurance Company:		
Insured Name:		Relationship:
Insured Employer:		Insured Social Security #:
Policy#:	Group #:	Co-pay: $

EMERGENCY CONTACT INFORMATION

Name of friend or relative:	Relationship to patient:	Home phone #:
Street Address:		Work phone #:
City:	State:	Zip Code:

FOOT & ANKLE INFORMATION

Describe your foot problem including how long it has been bothering you:

Describe any past problems with feet or ankles:

Employment	Sits at job ☐	Stands at job ☐	Stands and walks at job ☐	Retired ☐

Shoe size		**Current Weight**		**Height**	

PERSONAL HEALTH HISTORY

Check any of the following you have now or have had a problem with in the past

☐ Heart	☐ Depression	☐ Neurological Disorder	☐ Gout	☐ Asthma
☐ Circulation	☐ Stomach Ulcers	☐ Tuberculosis	☐ Intestines	☐ Cancer
☐ Arthritis	☐ Hormones	☐ Rheumatic Fever	☐ Thyroid	☐ High Blood Pressure
☐ Kidneys	☐ Anemia	☐ Liver	☐ Healing	☐ Frequent infections
☐ Lungs	☐ Bladder	☐ Unexplained weight loss	☐ Skin	☐ Diabetes
☐ Heart Implant (When?)		☐ Artificial Joints (Which?)		
☐ Other? (Please list)				

Check any allergies or reactions to drugs/medications

☐ Betadine (Iodine, etc) Please list:	☐ Narcotics (Codeine, etc) Please list:	☐ Latex
☐ Antibiotics (Penicillin, Sulfa, drugs, etc) Please list:		☐ Tape Please list:
☐ Local Anesthetic (Novocaine, Lidocaine, etc) Please list:		☐ Other medical allergies? Please list:
☐ Problems with aspirin or ibuprofen (Advil, Motrin,	Which?	Explain?

List any medications you are currently taking Prescription and over the counter

Medication	Dose	Medication	Dose

List any Major surgeries and all foot and ankle surgeries

Type of Surgery	Date	Type of Surgery	Date

Have you received a flu vaccine within the last year? ☐ Yes ☐ No Date: _____ **Pneumonia?** ☐ Yes ☐ No Date: _____

Are you currently under a physicians care? ☐ Yes ☐ No If yes, explain condition below:

FAMILY HEALTH HISTORY

Is there a family (blood relative) history of:

☐ Heart Disease	☐ Arthritis	☐ Stroke	☐ Diabetes	☐ Bleeding Disorder
☐ Bunions	☐ Hammertoes	☐ Flatfeet	☐ Neurological Disorder	☐ Circulation problems with legs and feet

Father	☐ Living ☐ Deceased	Cause:	**Sibling**	☐ M ☐ F	☐ Living ☐ Deceased	Cause:
Mother	☐ Living ☐ Deceased	Cause:	**Sibling**	☐ M ☐ F	☐ Living ☐ Deceased	Cause:

PERSONAL HEALTH HABITS

Tobacco	Do you use tobacco?	☐ Yes ☐ No	Number of packs per day?		Number of years?	
	Did you previously?	☐ Yes ☐ No	Number of years?		Year quit?	

Alcohol	Do you drink alcohol or beer?				☐ Yes	☐ No
	Light usage (1-2 per week)	☐	Moderate (1-2 per day)	☐	Heavy (more than 2 daily)	☐

AUTHORIZATIONS

I hereby authorize payments to the physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of the bill not covered by my insurance.

I hereby authorize release of information for insurance claim purposes. The information authorized for release may include information that may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

_____ _____

Signature of Insured Person *Date*

DEAR PATIENT, PLEASE READ THIS AND SIGN BELOW

The booklet accompanying this receipt is a 4-page, multi-color copy of our Notice of Privacy Practices, which provides a detailed description of what we do with health and personal information that we have about you.

It also explains your rights as a patient, for getting access to that information, and controlling its use and disclosure.

Per HIPAA regulations we are required to ask you to sign this Acknowledgement of Receipt of Notices of Privacy Practices.
You have the right to refuse our request, in which case, we must document your refusal for the record.

After reading the booklet you may take the booklet with you or leave it for the next patient.

Sign your acknowledgement below for having received your Notice of Privacy Practices and return this page to our staff.

Thank You!

PATIENT'S ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge that the practice of Mark N. Levy, DPM provided access to a copy *Notice* of *Privacy Practices* to read and keep as my own.

PATIENT Name Print

Print Name of Parent/Responsible Party (If applicable)

SIGNATURE of Patient/Parent/Responsible Party

Date ___/___/___

Relationship to Patient

Patient's Date Of Birth ___/___/___

Patient Identification # (Or Social Security No.)

INABILITY TO OBTAIN RECEIPT ACKNOWLEDGEMENT SIGNATURE

Practice staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? ☐ Yes ☐ No
2. Please explain why the patient was unable to sign an acknowledgement form and the Practice's efforts in trying to obtain the patient's signature:

___/___/___
Date

Staff Name (Please Print)

Staff Signature

Witness Name (Please Print)

Witness Signature