Nagy Footcare

WE PUT YOUR FEET FIRST.

WELCOME TO OUR OFFICE

Name_____ **Race**_____ **Preferred Language**_____
Last Name **First Name** **Middle Name**

Social Security # for Insurance purposes only_____

Home Address_____ **City**_____

State_____ **Zip**_____ **Home Phone**_____ **Cell Phone**_____

Sex __**Male** __**Female** **Marital Status** __**Single** __**Married** __ **Divorced** __**Widowed** __**Partner**

Date of Birth_____ **Email Address**_____ __ **Student** __**Fulltime** __ **Part-time**

Employer_____ **Occupation** _____

Employer Address_____ **City/State/Zip**_____

Primary Care Doctor _____ **Date Last Seen**_____

Phone/Address (Doctor) _____

Emergency Contact_____ **Phone**_____

How did you hear about our office?_____

Primary Insurance Company: _____
Subscriber I.D.# _____ Insurance Company's Phone_____
Policyholder's Name _____ Policyholder's Date of Birth _____
Insured Employer _____ Employer's Phone _____
Secondary Insurance Company: _____
Subscriber's I.D.# _____ Insurance Company's Phone_____
Policyholder's Name _____ Policyholder's Date of Birth _____
Insured Employer _____ Employer's Phone_____

To discuss or release ANY information about you to a family member or a friend (i.e. spouse, neighbor, caregiver…) you will need to put them on the below list.
************Authorization will only expire with written revocation from the patient*************

Name of person ***Relationship to Patient*** ***Effective Date***

_____

Responsible Party's Signature_____ **Date**_____

I hereby authorize Nagy Footcare to submit a claim to my insurance carrier for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to the physician rendering the covered service. I will be responsible for those charges deemed not covered by said insurance carrier so long as such insurance has not deemed such services to be medically inappropriate or unnecessary. I also understand that if my insurance company is not a contracted carrier, I am responsible for the full fee charged to my physician regardless of what my insurance pays. I authorize Nagy Footcare to furnish complete information to my insurance carrier and its intermediaries regarding the serviced rendered. I permit a copy of this authorization to be used in place of the original.

GENERAL HEALTH

NAME: _____ **DATE:** _____

Age: _____

What is the reason for your visit? _____

Do you have any of the following? Please Check yes or no.

	Yes	No	Family		Yes	No	Family
Anemia (low blood count)	__	__	__	High Blood Pressure	__	__	__
Arthritis – Type? _____	__	__	__	High Cholesterol	__	__	__
Back Problems	__	__	__	HIV/AIDS	__	__	__
Cancer – Type? _____	__	__	__	Kidney Disease	__	__	__
Chemical Dependency	__	__	__	Liver Disease	__	__	__
Circulatory Problems	__	__	__	Mental Illness	__	__	__
Diabetes	__	__	__	MRSA Infections	__	__	__
DVT (Blood Clot)	__	__	__	Pacemaker	__	__	__
Epilepsy	__	__	__	Prostate Problems	__	__	__
GI Problems	__	__	__	Respiratory Disease	__	__	__
Heart Murmur	__	__	__	Sleep Apnea	__	__	__
Heart Disease	__	__	__	Stroke	__	__	__
Hepatitis – Type A, B or C? ____	__	__	__	Thyroid Problems	__	__	__

Please list any operations you have had _____

_____

Pharmacy Name/City _____

Please list all prescription and non-prescription medications you are currently taking _____

_____

_____

Please list all your drug allergies _____

Flu Shot ___**Yes** ___**No** **Date**_____ **Pneumonia Shot** ___**Yes** ___**No** **Date**_____

Height _____ **Weight** _____ **Shoe Size** _____

Woman Only: Is there any possibility you may be pregnant? Yes or No

Social History: Do you smoke? Yes or No How many Packs a day? Quit, When?

Please indicate how much alcohol you consume:

None: _____ Beers per week: _____

Glass of wine per week: _____ Glass of liquor per week: _____

NAGY FOOTCARE

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE & FINANCIAL RESPONSIBILITY

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Nagy Footcare, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and my include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits : I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any coinsurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. If for any reason my insurance plan does not pay for my approved charges in full, I agree to be fully responsible for the amount. I also agree, should collections be necessary for payment of my account, to be fully responsible for any collections fees and associated costs.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____