WESTSIDE PODIATY
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name ____

Date of Birth ________/________/________ ☐ Male ☐ Female

Address ____

City____

State____________________ Zip Code________________

Home Phone (________) ____________-______________

Cell Phone (________) ____________-______________

E-Mail ____

@______________________.______________________

Social Security # ______________________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ American Indian or Alaskan Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian

☐Hispanic or Latino ☐ Other

Occupation ____

Employer____

Address ____

City____

State____________________ Zip Code________________

Work Phone (________) ____________-______________

Ext. ____

SPOUSE INFORMATION

Name ____

Home Phone (________) ____________-______________

Cell Phone (________) ____________-______________

Other Phone (________) ____________-______________

EMERGENCY CONTACT (IF OTHER THAN SPOUSE)

Name ____

Relationship____

Home Phone (________) ____________-______________

Cell Phone (________) ____________-______________

INSURANCE INFORMATION

Primary Insurance Co. Name ______________________________

Subscriber Name ______________________________________

Subscriber Date of Birth __________/__________/__________

Subscriber Employer (If Not Self) __________________________

☐ Self ☐ Spouse ☐ Mother ☐ Father

☐ StepMother ☐StepFather

Secondary Insurance Co. Name ______________________________

Subscriber Name ______________________________________

Subscriber Date of Birth __________/__________/__________

☐ Self ☐ Spouse ☐ Mother ☐ Father

☐ StepMother ☐StepFather

PHARMACY INFORMATION

Pharmacy Name ______________________________________

Address ____

City____

State____________________ Zip Code________________

PHYSICIAN INFORMATION

Primary Care Physician ______________________________

____

Date Last Seen by PCP __________/__________/__________

Referring Physician (If Different Than PCP) ________________

____

PARENT/GUARDIAN INFORMATION (COMPLETE ONLY IF PATIENT UNDER AGE 18)

Name ____

Relationship____

Home Phone (________) ____________-______________

Cell Phone (________) ____________-______________

Date of Birth ________/________/________ ☐ Male ☐ Female

Address ____

City____

State____________________ Zip Code________________

IS YOUR TREAMENT TODAY DUE TO:

……………..A Work-Related Injury ☐ Yes ☐ No Injury Date__________/_________/__________

Do you have written authorization from your employer and worker's comp carrier to be treated? ☐ Yes ☐ No

……………..An Accident/Liability Case ☐ Yes ☐ No Accident Date__________/_________/__________

Do you have a Letter of Protection on File with an attorney? ☐ Yes ☐ No

……………..A Motor Vehicle Accident ☐ Yes ☐ No Accident Date__________/_________/__________

WHOM MAY WE THANK FOR SENDING YOU TO OUR OFFICE?

☐ Web Site ____

☐ Other ____

☐ Patient ____

☐ Insurance Provider Lise

☐ Passed by Location

☐ Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

SIGNATURE X____ DATE___________/___________/____________

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Westside Podiatry** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<table>
<tr><td colspan="2">PATIENT'S NAME (Please Print)</td><td>PROVIDER: Name, Address, and Zip</td></tr>
<tr><td colspan="2"></td><td rowspan="5">Westside Podiatry 13114 FM 1960 W
Suite 100
Houston, TX 77065</td></tr>
<tr><td colspan="2">PATIENT'S SIGNATURE:</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>PATIENT'S MEDICARE NO.</td><td>DATE:</td></tr>
<tr><td></td><td></td></tr>
</table>

Patient Name: ____ Date of Birth: ____________________

Referring Physician Name and Address: ____[1]

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left____

   ____

2. **When did pain/discomfort begin (date): ____**

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ____________________

3. **What makes the pain/discomfort better: ____**

4. **Have you had a physical trauma?** ☐ No ☐ Yes ____

5. **Have you had an accident?** ☐ No ☐ Yes ____

6. **Occupation:______________________Is your problem work related?** ☐ Yes ☐ No

7. **Past Medical History:**

   ☐ Anemia ☐ Bleeding Disorders ☐ Cancer _____________ ☐ Diabetes ☐ Epilepsy

   ☐ Gout ☐ Heart failure ☐ Hepatitis ☐ High Cholesterol ☐ HIV / AIDS ☐ High Blood Pressure

   ☐ Kidney Disease ☐ Lung/Respiratory Disorders ☐ Mitral Valve Prolapse ☐ Nerve Disorders ☐ Neurological Disorders ☐ Prostate Disorders

   ☐ Osteoarthritis ☐ Other Arthritis ☐ Rheumatic Fever ☐ Stroke ☐ Thyroid Disorders ☐ Other: ____________

8. **List all medications/herbs/vitamins:** ☐ **NONE**____

   ____

9. **Allergies:** (Describe reaction) ☐ **NONE**

   ☐ Penicillin__________________ ☐ Aspirin________________ ☐ Narcotic Agent / Codeine ___________

   ☐ Anesthesia ________________ ☐ Shellfish ________________ ☐ Sulfa Drugs ____________________

   ☐ Nickel / Metal______________ ☐ Radiographic Contrast Dye______________________________

   ☐ Other ____

10. **Are you currently pregnant?** ☐ No ☐ Yes ____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

    Surgery / Date: ____

    ____

12. **Social History:** (Only check what is pertinent to you)

    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits______________________________

    ☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**

    ☐ Diabetes_________________ ☐ Heart Disease ________________ ☐ Kidney Disease ________________

    ☐ Hypertension______________ ☐ Stroke________________________ ☐ Mental Illness__________________

    ☐ Rheumatology _____________ ☐ Bleeding Disorders ____________ ☐ Cancer _________________________

    ☐ Other family History:____

14. Shoe Size: _________________15. Height: ________________________ 16. Weight: ________________________

Patient Name: ____ Date of Birth: ____________________

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change

Head, Eyes, Ears, Nose and Throat		
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses
☐ Double Vision	☐ Cataract	☐ Dizziness
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears

Cardiovascular		
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations

Hematologic/Lymphatic		
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma
☐ Anemia	☐ Skin Lump - Location	

Respiratory		
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms

Gastrointestinal		
☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation

Endocrine		
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease

Musculoskeletal		
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia
☐ Weakness of limbs	☐ Prior Fracture	

Nervous System		
☐ Ataxia	☐ Speech Difficulties	☐ Headache
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting
☐ Convulsions		

Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	

Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular

Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

Westside Podiatry
13114 FM 1960 Rd West, Suite 100
Houston, Texas 77065

Office: 281-859-6100
Fax: 281-859-8199

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Your Rights: **When it comes to your health information, you have certain rights**:

- **Get an electronic or paper copy of your medical record**: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. A fee may apply.
- **Ask us to correct your medical record**: You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **Request confidential communications**: You can ask us to contact you in a specific way (for example: home or office phone) or to send via mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use or share**: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information**: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you have us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**: You can ask for a paper copy of this notice at any time, even if you have received the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make decisions about your health information on your behalf. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated**: You can complain if you feel we have violated our rights by contacting us at the location listed above. You can file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, D.C. 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: **For certain health information, you can tell us our choices about what we share**. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and will follow your instructions.

- In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or other involved in your care; Share information in a disaster relief situation. *If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- In these cases, we never share your information unless you give us written permission: Marketing purposes, Sale of your information; Most sharing of psychotherapy notes.

Our uses and disclosures: **We typically use or share your health information in the following ways**:

- **Patient treatment**: We can use your health information and share it with other professionals who are treating you.
- **Run our organization**: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- **Bill for your services**: We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share our information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many condition in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- We can share health information about you for certain situations such as: Preventing diseases; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety.
- We can use or share your information for health research.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy laws.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual passes away.
- We can share health information about you to address worker's compensation, law enforcement, and other government requests, as authorized by law.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice: We can change the terms of this notice, and the changes may apply to all information we have about you. If new changes occur, the new updated notice will be available upon request, in our office, and on our web site.

Acknowledgement of Notice of Privacy Practices

I have received and read the Notice of Privacy Practices for Westside Podiatry. I authorize WSP to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my health insurance to WSP. I understand that I am fully responsible for any non-covered payments due to WSP that are not covered by Worker's Compensation, Medicare, and other insurance plans. I consent to the use of sharing of my health records for treatment, payment, and operational purposes as described in the Notice of Privacy Practices.

____ ____

Print Patient Name | Signature of Patient

____ ____

(Office use only) Witness – Print Name | (Office use only) Witness – Signature

____

(Date)

Authorization to Release Information to a Family Member/Friend/Caregiver

Westside Podiatry maintains a confidentiality policy with all patient's medical information. Please list the names of those individuals that you give the office permission to speak with concerning your medical condition and needs.

I, ____ hereby give permission for Westside Podiatry to give information regarding my medical condition and needs to the following individuals (Family Member, Friend, Caregiver)

Name of Person	DOB	Phone Number	Email	Date