

DONAHUE FOOT AND ANKLE CENTER INC
PATIENT REGISTRATION

Patient Name _____ Male Female Birthdate _____
(Print)

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Cell Phone (____) ____ - ____ Work Phone (____) ____ - ____ SSN ____ - ____ - ____

Marital Status: Married Widowed Single Minor Separated Divorced Partnered

Employer/School: _____ Occupation: _____

Preferred Language: _____ Email Address: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Not Specified

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White Not Specified

May we leave a message at your home or with residents? Yes No On your answering machine/voicemail? Yes No

Whom may we thank for referring you? _____

Person we may talk to about your medical concerns: _____ Relationship _____ Phone: _____

Is this contact only for emergency purposes only? Yes No, they can be contacted regularly about my care

For minors only: Child lives with both parents Mother Father Emancipated Minor Other

Parent/Guardian _____ Address (if different) _____

Date of Birth: _____ Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

Responsible Party for insurance and bills: Patient Spouse Parents Mother Father Other _____

Primary Insurance Company: _____ Name on Contract: _____

Contract ID # _____ Group # _____ DOB _____

Relationship to cardholder: Self Spouse Dependent Card Copied Yes No Co-payment: \$ _____

Secondary Insurance Company: _____ Name on Contract: _____

Contract ID # _____ Group # _____ DOB _____

Relationship to cardholder: Self Spouse Dependent Card Copied Yes No Co-payment: \$ _____

Identification of other physicians/health care entities involved with my medical whom I authorize ongoing release of information for continuity of care:

Primary Care Physician: _____ Phone (____) ____ - ____

Address: _____ Zip _____

Other Physician: _____ Phone (____) ____ - ____

Specialty: _____

Pharmacy Name: _____ Address: _____ Zip _____

Pharmacy Phone: _____

Signature: _____ Date: _____

Information reviewed: ____/11 ____/12 ____/13 ____/14 ____/15 ____/16 ____/17 ____/18 ____/19

**Statement of Assignment of Benefits, Financial Responsibility, Consent for Purposes of Treatment, Payment and Healthcare Operations,
Acknowledgment of Receipt of Notice of Privacy Practices, and
Authorization for Use or Disclosure of Protected health Information**

Assignment of Benefits

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Workers' Compensation or any other governmental or private insurance or health plans to the **Donahue Foot and Ankle Center, Inc., (DFAC), 3731 Pearl Road, Cleveland, Ohio 44109.** This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Financial Responsibility

I understand that I am responsible for all charges, whether or not I have insurance. In the event that I have insurance with a plan that has a participation agreement with DFAC I understand that I am responsible for all deductibles, co-payments and co-insurances. In the event that I do not have insurance with a plan that has a participation agreement with DFAC, I understand that I am responsible for the full difference between DFAC billed charges and any amount paid by insurance.

Consent to Use Protected Health Information for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by DFAC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DFAC. I understand that diagnosis or treatment of me by DFAC may be conditioned upon my consent as evidenced by my signature on this document.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the DFAC Notice of Privacy Practices.

Authorization for Use or Disclosure of Protected Health Information (Please check all that apply)

- I do not authorize DFAC physicians and/or administrative and clinical staff to use or released the following protected health information for the purpose listed below

- I authorize DFAC physicians and/or administrative and clinical staff to use the following protected health information,
 - entire record
 - problem list
 - medication list
 - list of allergies
 - immunization records
 - most recent history
 - most recent discharge summary
 - lab results (please describe the dates or types of lab tests you would like disclosed):
 - x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed)
 - consultation reports from (please supply doctors names):
 - other (please describe):

and to disclose the following protected health information to: (Please check all that apply and describe)

- My Spouse _____
- My Family Members _____
- My Telephone and/or Voice Mail _____
- Patient's Non-Custodial Parent _____
- Other _____

This protected health information is being used for disclosed for the purpose of expediting communication of my treatment and care.

This authorization shall be in force and effect for twelve months from the date recorded below at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at:

Our Privacy Contact _____ may be contacted at 216-459-8616
Donahue Foot and Ankle Center, Inc.
3731 Pearl Road
Cleveland, OH 44109

I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

DONAHUE FOOT and ANKLE CENTER, INC.

Patient Registration - Part II

DATE _____

NAME _____ B.P. _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

Have you had / used any of the following:

- Yes ___ No ___ Diabetes
- Yes ___ No ___ Insulin
- Yes ___ No ___ Heart Trouble
- Yes ___ No ___ Mitral Valve Prolapse
- Yes ___ No ___ Stroke
- Yes ___ No ___ Arthritis/Gout
- Yes ___ No ___ Convulsions
- Yes ___ No ___ High Blood Pressure
- Yes ___ No ___ Bleeding Tendency
- Yes ___ No ___ Bone Infection
- Yes ___ No ___ Other Infection
- Yes ___ No ___ Cancer of _____

Have you ever had Allergies to any of the following:

- Yes ___ No ___ Penicillin
- Yes ___ No ___ Other Antibiotics
- Yes ___ No ___ Aspirin
- Yes ___ No ___ Novocaine
- Yes ___ No ___ Local Anesthetics
- Yes ___ No ___ Codeine
- Yes ___ No ___ IVP Dye
- Yes ___ No ___ Adhesive Tape
- Yes ___ No ___ Iodine
- Other _____

Current Medications Including Over the Counter Vitamins/Natural Supplements

- Yes ___ No ___ Smoke #Packs Daily _____
- Yes ___ No ___ Drug Use Frequency _____
- Yes ___ No ___ Alcohol Use Frequency _____

- CURRENT EVERYDAY SMOKER
- CURRENT SOMEDAY SMOKER
- SMOKER, CURRENT STATUS UNKNOWN
- FORMER SMOKER
- NEVER SMOKER
- UNKNOWN, IF EVER SMOKED

Have you been hospitalized in the past year? Yes/Why? _____

List your surgeries and dates: _____

Circle your family history of the following:

Diabetes High Blood Pressure Stroke Cancer Foot Problems High Cholesterol Heart Disease

Reason for Today's Visit: _____

What symptoms are you having? _____ Pain _____ (1 being little pain, 10 being extreme pain)

_____ Swelling _____ Burning _____ Tingling _____ Grinding _____ Numbness _____ Grating _____

What causes or aggravates your symptoms? _____

What decreases or alleviates your symptoms? _____

What is your goal of treatment? _____

Have you been treated in the past for this problem? Yes ___ No ___ When: _____

By Whom _____

MARK THE AREA (S) BELOW TO IDENTIFY ANY PROBLEMS YOU MAY BE HAVING

