CAHABA PODIATRY
DR. LORA YEAGER-SMITH
CAHABAPODIATRY.COM

Patient Registration Form

First Name: _____ Last Name: _____ Middle: _____

DOB: _____ Sex: M / F Marital Status: Single / Married / Separated / Widowed

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ May we leave a confidential message on your voicemail? Y / N

Whom may we thank for referring you to our offices? _____

Race: _____ Hispanic / Non-Hispanic Primary Language: _____

Emergency Contact: _____ Phone Number: _____ Relationship_____

Primary Care Physician: _____ Date last seen: _____ Are you Diabetic? Yes/No

Pharmacy: _____

Insurance Information:

Primary Insurance: _____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Subscriber: _____

The above information is true to the best of my knowledge. I will notify Cahaba Podiatry of any changes.

Cahaba Podiatry will bill to your insurance company on your behalf for services rendered. I authorize my insurance benefits to be paid directly to Cahaba Podiatry. I understand that I am financially responsible for my balance. I also authorize Cahaba Podiatry and/or the insurance company to release any information required to process my claims. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as the original.

Patient or Guardian Signature: _____ Date: _____

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Patient Medical History

Patient Full Name: _____ Date: _____
What type of foot condition are you being seen for? _____
How long have you been suffering with this condition? _____
Is this a work-related injury? Yes / No If yes, please give the date of the injury: _____
Employer Name: _____ Occupation: _____
Shoe Size: _____ Marital Status: Single / Married / Separated / Widowed
Do you smoke? Yes / No If yes, How many packs per day? _____ How many years? _____
Do you drink alcohol? Yes / No How frequently? Rarely / Socially / Daily
Are you Diabetic? Yes / No What Type: _____ If yes, do you take insulin? Yes / No
Family Medical History: Diabetes- Who? _____ Cancer-Who? _____ Blood Clots- Who? _____ Stroke-Who? _____ Asthma- Who? _____ Other- Who? _____
Please list **ALL** medications you are currently taking and why you are taking these medications (or attach a list):

Medication	Why do you take this?	Medication	Why do you take this?

Please list any diagnoses not listed above:_____
_____
Please list ANY allergies to ANY medications:_____
Please list ALL major surgeries (*within the past 10 years*):_____

REVIEW OF SYSTEMS (*circle all that apply*):

Constitutional: Fever Night sweats Exercise Intolerance Weight Gain Weight Loss
Eyes: Dry eyes Irritation Vision Change
ENMT: Difficulty Hearing Ear Pain Frequent Nosebleeds Nose Problems Sinus Problems
Cardiovascular: Chest / Arm pain Shortness of Breath Palpitations Heart Murmur Light Headed upon Standing
Respiratory: Cough Wheezing Shortness of Breath Coughing up Blood Sleep Apnea
Gastrointestinal: Abdomen Pain Appetite Change Vomiting Tarry Stools Diarrhea Vomiting blood GERD
Genitourinary: Loss of Control Difficulty Urinating Increased Urinary Frequency Hematuria Incomplete Emptying
Musculoskeletal: Aches Weakness Arthralgias/Joint Pain Back Pain Swelling in the Extremities
Skin: Abnormal Mole Jaundice Rash Itching Dry Skin Growth/Lesions Lacerations
Neurologic: Loss of Consciousness Weakness Numbness Seizures Dizziness Frequent Headaches Migraines Restless Legs Tremor
Psychiatric: Depression Sleep Disturbances Feeling Unsafe in Relationship Restless Sleep Alcohol Abuse Anxiety Hallucinations Suicidal Thoughts
Endocrine: Fatigue Excessive Thirst Hair Loss Hair Growth Cold Intolerance
Hematologic/Lymphatic: Swollen Glands Easy Bruising Excessive Bleeding Chronic Swelling of Legs
Allergic/Immunologic: Runny Nose Sinus Pressure Itching Hives Frequent Sneezing

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FINANCIAL AND CANCELLATION POLICY

We are pleased to offer you the service of billing your insurance company for the care you have received from our doctors. It is your responsibility to notify us of any changes in your insurance coverage.

If you are uninsured, payment is due in full on the date of service, or payment must be made in advance. For insured patients, co-pays and deductibles are due on the date of service provided to you in the office.

The fees we charge for services are usual and customary for this area. Your health insurance policy may base its allowances on a fixed fee schedule that may or may not coincide with our usual fees. You should be aware that different companies may vary greatly in the type of coverage available.

Ultimate responsibility of payment for services rendered is yours.

For our Medicare patients, we agree to accept the charge determination of the Medicare carrier as the full charge. You are responsible only for the deductible, coinsurance, and non-covered services as determined by the Medicare carrier.

I hereby authorize Cahaba Podiatry to release to any insurance company, physician, or hospital all medical information which is necessary to afford proper treatment or obtain payment for services. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I have read and fully understand the above, and I realize that I am responsible for any charges not covered by my insurance.

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments below:

A MISSED APPOINTMENT IS WHEN YOU FAIL TO SHOW UP FOR AN ALLOTTED APPOINTMENT TIME, WITHOUT A PHONE CALL OR CANCELLATION NOTICE OF (AT LEAST) 24 HOURS.

A $15 fee will be assessed for each appointment that fails to comply with the above policy.

Print Name:_____

Patient or Guardian Signature:_____Date:_____

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ACKNOWLEDGEMENT OF HIPAA POLICY

Cahaba Podiatry provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.
If you ever believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
How will we use or disclose your information? Here are a few examples: -For medical treatment & referrals
-To obtain payment & file insurance
-In emergency situations
-In response to certain requests arising out of lawsuits or ---other disputes
-For workers compensation programs
-For research and education
-To prevent serious threats to health safety
-For appointment and patient recall reminders
-To run our Practice more efficiently and insure all our -----patients receive quality care
You have certain rights regarding the information we maintain about you. These rights include:
-The right to inspect and copy -The right to paper copy of this notice
-The right to amend -The right to request confidential communications
-The right to an accounting of disclosures -The right to request restrictions

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Cahaba Podiatry may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for care by the doctor and staff of Cahaba Podiatry. You hereby grant full authority to the Podiatrist and their respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to or upon your person, which may be advised or necessary.

Effective Date :This notice is in effect as of March 28, 2017

Patient Acknowledgement
By signing below, I acknowledge that I have completely read the information above.
I have full understanding and agree to its terms.

Print Name: _____

Patient or Guardian Signature: _____ Date: _____