Southwest Foot & Ankle, LLC

REGISTRATION FORM

Today's Date: ______________ Primary Care Physician: ________________________

PATIENT INFORMATION

Last Name: ____________________ First Name: __________________ Middle Initial: _____
DOB: ______________ Marital Status: _____________
Home Phone: _________________ Cell Phone: ________________ Email: __________________
Home Address: ________________________ SS#: ________________________
____

Occupation: ________________________ Employer/Phone#: __________________

Who referred you to our office: ____________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person Responsible for bill: ___________ DOB: __________ Address (if different): _________________
____

Occupation: ________________________ Employer/Phone#: __________________

Primary Insurance: __________________________
Subscriber's Name: __________________________ Subscriber's DOB: ___________
SS#: _________________
Group #: ________________ Policy #: ________________ Co-Pay $: ___________
Patient's relationship to subscriber: _______________________

Secondary Insurance: __________________________
Group #: ________________ Policy #: ________________

IN CASE OF EMERGENCY

Name of local friend/relative: ___________________________
Relationship to patient: ____________________________
Home Phone #: ____________________ Work Phone #: ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Southwest Foot & Ankle, LLC/Dr. Brian C. Rell. I understand that I am financially responsible for any balance. I also authorize Southwest Foot & Ankle, LLC or insurance company to release any information required to process my claims.

_______________________________ _______________________________
Patient/Guardian Signature Date:

Southwest Foot & Ankle Dr. Brian C. Rell

6310 Health Park Way Suite 345, Lakewood Ranch, FL 34202 | P: 941-256-3873 | F: 941-355-2292

LIFETIME SIGNATURE AUTHORIZATION

Dear Patient:
Southwest Foot & Ankle, LLC (SWFA) is pleased that you have selected this office to provide for your medical needs. SWFA is asking you to review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. If you are comfortable with the document, please sign and date where indicated and return it to our receptionist. If you disapprove, SWFA certainly respects your right of refusal. However, please be aware that SWFA, without your legal signature, cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, SWFA will have no alternative but to require that you be responsible for the cost of services rendered in full.

LIFETIME AUTHORIZATION STATEMENT

SWFA agrees to bill my health/auto insurance carrier and/or Medicare Part B whenever possible. I request my health/auto insurance carrier to pay SWFA directly all benefits due me related to my pending claim for medical and/or surgical services. I understand that SWFA does accept assignment for Medicare and payments will be directed to SWFA. I also understand that I will be responsible for all unpaid balances for services rendered, whether they are due to applicable co-payments, deductibles, non-covered services and items, unauthorized services, or any fees denied. Should the account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

CONSENT FOR TREATMENT

I authorize SWFA to treat as necessary for which my minor child or I are being seen. This includes, but is not necessarily limited to, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury or illness.

RELEASE OF MEDICAL RECORDS

I hereby authorize SWFA to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the patient's charges, including insurance companies, health care service plans, workman's compensation carriers, to the extent necessary to obtain reimbursement. Also, to the patient personal physician, referring physicians, or primary care physician.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

______________________________ ____________ __________________

Signature of Patient/Responsible Party   Date   Health Ins. ID#

Beneficiary Name

Southwest Foot & Ankle Dr. Brian C. Rell

6310 Health Park Way, Lakewood Ranch, FL 34202 | P: 941-256-3873 | F: 941-355-2292

Acknowledgement of Privacy Practices

(HIPAA)

I,______________________________ have been offered a Notice of Privacy Practices to inform me of how Southwest Foot and Ankle will use and disclose my protected health information.

____ ___________

Signature of Patient or Legal Representative **Date**

SOUTHWEST FOOT & ANKLE, LLC
Dr. Brian C. Rell

(Office use only) MR # ________

PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Date: ____

Patient Name: ______________________________ Date of Birth: __________________

Family/Primary Doctor: ______________________________ Phone: ______________________

Address: ____

Who referred you to our practice? (name & address please) ______________________________

____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Circle the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Age: __________ Sex: ______________ Marital Status: ______________ Handed: R/L ________

Height: ______________ Weight: ______________

Occupation: ____

What are you seeing the doctor for? ____

Duration of Symptoms: ____

When did the problem first start or when did the injury occur? ______________________________

Is this injury work related? Yes / No

Have you seen a doctor in the past for this problem or injury? Yes / No If yes, who and when? ________________

____

Explain in your own words how this injury occurred: ______________________________

____

____

____

What treatment have you had? ____

____

____

____

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphine
(F) Erythromycin
(G) Codeine
(H) Iodine/Betadine
(I) Radiographic Dyes
(J) Adhesive Tape
(K) Other (Specify):

Circle any of the medical problems listed below that you have now:

(A) I have no known medical problems.
(B) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers
(J) Hepatitis A / B / C
(K) Cancer
(L) Tuberculosis
(M) Liver disease
(N) Seizure disorder
(O) Thyroid disease
(P) Emphysema
(Q) COPD/Lung problem
(R) Immune disorder
(S) Overweight
(T) Osteomyelitis
(U) Blood Clot (DVT)
(V) Osteoporosis
(W) Other (Specify): ______________________________

How much alcohol do you consume?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 2-3 drinks per day
(G) An average of 3-4 drinks per day
(H) More than 6 drinks a day

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 ____________ packs/day
I have smoked for years
(B) No, but I used to smoke I smoked for __________ years
(C) No, I have never smoked

Do you now, or have you ever used drugs?

(A) Recreational
(B) Cocaine
(C) Marijuana
(D) Other (Specify): ______________________________

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): ______________________________

Have you ever had a blood clot? Yes No

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

(A) No previous surgeries

(B) Appendectomy

(C) Cataract extraction

(D) By-pass / open heart

(E) Gall bladder ______________________

(F) Hernia repair ______________________

(G) Hysterectomy ______________________

(H) Lumbar laminectomy

(I) Mastectomy

(J) Tonsillectomy

(K) Prostate surgery ______________________

(L) Other (Specify): ______________________

Any previous broken bones: ____

Blood transfusion: Yes / No Year: ______________

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen

Oruvail Tylenol Ultram Other: ______________________________

Please circle any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting

Other: ____

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta

Pepcid Prevacid Prilosec Tagamet Zantac

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS			COMMENTS
Chest Pain	Yes	No	
Dizziness	Yes	No	
Dry cough	Yes	No	
Productive cough	Yes	No	
Difficulty breathing	Yes	No	
Irregular heartbeat	Yes	No	
Swelling in the legs	Yes	No	
Lack of appetite	Yes	No	
Nausea	Yes	No	
Vomiting	Yes	No	
Diarrhea	Yes	No	
Constipation	Yes	No	
Abdominal cramping	Yes	No	
Varicose veins	Yes	No	
Bruising	Yes	No	
Bleeding	Yes	No	
Nose bleeds	Yes	No	
Joint pain and/or stiffness	Yes	No	
Muscle pain or muscle cramps	Yes	No	
Difficulty seeing	Yes	No	
Difficulty hearing	Yes	No	
Difficulty swallowing	Yes	No	
Difficulty sleeping	Yes	No	

Everything I have answered is true and correct to the best of my knowledge.

____

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD
AT SOUTHWEST FOOT & ANKLE, LLC