

PATIENT REGISTRATION SHEET

NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
Last First M.I

SOCIAL SECURITY# \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
(SS# is MANDATORY, PLEASE PROVIDE)

SEX: MALE/FEMALE HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

EMPLOYER NAME/PHONE \_\_\_\_\_

SPOUSE NAME OR PARENT/GUARDIAN IF MINOR: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER OF SPOUSE/PARENT \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

DO YOU TAKE BLOOD THINNERS, INCLUDING ASPIRIN? YES NO

DO YOU SMOKE CIGARETTES? YES NO

ARE YOU INSULIN DEPENDANT DIABETIC? YES NO

PLEASE LIST ANY OTHER MEDICAL CONDITIONS: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

WHAT ARE WE SEEING YOU FOR TODAY? \_\_\_\_\_

WHO IS THE PRIMARY INSURED? \_\_\_\_\_

WHO IS RESPONSIBLE FOR THIS ACCOUNT: \_\_\_\_\_

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND YOUR DRIVERS LICENSE.

I HEREBY CONSENT TO AND GIVE MY PERMISSION FOR DR. MICHAEL DREWS (AND ASSISTANTS) TO PROVIDE MEDICAL CARE TO ME OR MY CHILD AS DEEMED NECESSARY TO DIAGNOSE AND TREAT THE CONDITION I AM BEING SEEN FOR. THIS INCLUDES X RAYS, INJECTIONS, CASTING AND ANY OTHER MEDICAL SERVICES PROVIDED.

\_\_\_\_\_  
PATIENT SIGNATURE OR PARENT/GUARDIAN DATE

1. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE/MEDICAID)
2. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY
3. AGREEMENT TO FINANCIAL POLICIES FOR ASSOCIATED PODIATRISTS, P.C.

**ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS/MEDICARE/MEDICAID**

**INSURANCE COMPANY:** \_\_\_\_\_

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE AND MEDICAID) BE MADE DIRECTLY TO ASSOCIATED PODIATRISTS, PC/DR. MICHAEL DREWS. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE CLAIM SUBMISSIONS. THE ABOVE NAMED DR. MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO MY INSURANCE COMPANY FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR BENEFITS PAYABLE FOR THE RELATED SERVICES. THE CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY:**

I HAVE BEEN PRESENTED WITH A COPY OF THIS PROVIDERS PRIVACY POLICY, DETAILING HOW MY INFORMATION WILL BE USED AND DISCLOSED AS PERMITTED UNDER STATE AND FEDERAL LAWS. I UNDERSTAND THE CONTENTS OF THIS NOTICE, AND SUBJECT TO THE FOLLOWING RESTRICTION(S)/ALLOWANCES CONCERNING MY PERSONAL MEDICAL INFORMATION, I AGREE TO THE DISCLOSURES NAMED IN THE NOTICE: \_\_\_\_\_

**FINANCIAL POLICIES/INTEREST CHARGES:**

ASSOCIATED PODIATRISTS, P.C. DOES NOT FINANCE ANY PATIENT ACCOUNTS. IF WE FILE YOUR INSURANCE AND CHARGES ARE APPLIED TO YOUR DEDUCTABLE OR COINSURANCE AMOUNT, THE BALANCE IS DUE IN 30 DAYS. FOR PATIENTS HAVING SURGERY THAT HAVE NOT YET MET THEIR DEDUCTABLES, PAYMENT OF THE DEDUCTABLE AMOUNT IS DUE IN FULL PRIOR TO THE SURGERY. CUSTOM ORTHOTICS MUST BE PAID FOR IN FULL PRIOR TO THE CASTS BEING SENT TO THE LAB. IF YOU HAVE INSURANCE COVERAGE FOR THEM, WE WILL FILE THE CLAIM. IF YOUR INSURANCE COMPANY REIMBURSES OUR OFFICE FOR THE ORTHOTICS, THEN OUR OFFICE WILL REIMBURSE YOU IN THE SAME MANOR YOU PAID (CHECK IF PAID WITH CASH) WITHIN 5 WORKING DAYS OF OUR OFFICE RECEIVING PAYMENT. *IF THERE IS NO INSURANCE COVERAGE, PAYMENT IN FULL IS REQUIRED ON THE DAY SERVICES ARE PROVIDED. OUR OFFICE WILL CHARGE A 16% (ANNUAL) INTEREST CHARGE ON ALL PATIENT ACCOUNTS THAT ARE OVER 60 DAYS PAST DUE. OUR OFFICE WILL SEND ONE STATEMENT REMINDING YOU THAT YOUR PAYMENT IS DUE. IF ADDITIONAL STATEMENTS ARE REQUIRED, YOU WILL BE CHARGED A \$5.00 FEE PER STATEMENT. IN THE UNFORTUNATE EVENT THAT OUR OFFICE IS FORCED TO TURN AN ACCOUNT OVER FOR COLLECTIONS, YOU WILL BE RESPONSIBLE FOR ALL FEES ASSOCIATED WITH THE COLLECTION PROCESS. I UNDERSTAND, REGARDLESS OF INSURANCE COVERAGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE