JOSEPH C. TAUB, DPM PA

Today's Date _____

PODIATRY PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

Patient Name _____
First Name M.I. Last Name

Phone # _____/_____
Home Phone Cell Phone

Address_____

City _____ **ST** _____ **Zip** _____

Email _____

Would you like to receive our Newsletter? Yes / No

Sex M / F **Age** _____ **D.O.B** _____/_____/_____

Marital Status M S W D **Race** _____

Primary Language _____

Occupation _____

Pharmacy Name_____
Pharmacy Location _____

Primary Physician _____ **Last Seen** _____

Emergency Contact _____
Phone Number _____

How did you hear about us? _____

FOOT NOTES

Height _____ **Weight** _____ **Shoe Size** _____

Diabetic YES / NO **Last Check-Up** _____
If Yes, to Diabetes
Diabetic Doctor _____
Average Sugar _____ **Insulin Depdnt** YES / NO
Oral Meds YES / NO **Diet Control** YES / NO

Foot Surgery YES / NO
If Yes, When _____ **Where** _____

Reason for Visit _____
Duration _____
Experiencing Pain? Sharp Dull Ache Burning
Reason for Onset _____
Treated by a Doctor? YES / NO

SOCIAL HISTORY

Tobacco Yes / No
If Yes, Amount _____ **How Long** _____
***Former Use*? How Long Ago** _____

Immunizations up to Date Yes / No

Flu Vaccine Yes / No

Pneumonia Vaccine Yes / No

Alcohol Use Yes / No
If Yes, Amount _____

SURGICAL HISTORY – PLEASE LIST ON THE PROVIDED LINES

_____

_____

☐ **NO SURGICAL HISTORY**

MEDICAL HISTORY – PLEASE CHECK ANY KNOWN CONDITIONS YOU HAVE, OR HAD PREVIOUSLY: ☐ NO MEDICAL HISTORY

ANEMIA	BUNIONS	GOUT	KIDNEY PROBLEMS
ARTHRITIS	BURSITIS	HEPATITIS B / C	LIVER DISEASE
ARTIFICIAL JOINTS/VALVES	CANCER	HEART PROBLEMS	MUSCULAR DISORDERS
ASTHMA	CIRCULATION	HIGH BLOOD PRESSURE	SWELLING
BLEEDING DISORDER	DIFFICULTY	HIGH CHOLESTROL	ULCERS
BLOOD DISEASE	EPILEPSY	HIV/ AIDS	WEAKNESS
DIABETES	OTHER:		

MEDICATIONS – PLEASE LIST YOUR CURRENT MEDICATIONS & DOSAGE ON THE PROVIDED LINES ☐ SEE ATTACHED LIST

_____

_____

ALLERGIES – PLEASE LIST ANY ALLERGIES ON THE PROVIDE LINES ☐ NO KNOWN DRUG ALLERGIES

_____

_____

MEDICAL RELEASE & HIPPA NOTIFICATION FORM

Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

_____

Signature

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance. We accept payment in the form of cash, check, and all major credit cards.

*Patient financial responsibilities that remain unpaid could be sent to Collections if past 90 days.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Joseph C. Taub,DPM PA when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Joseph C. Taub, DPM PA for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____

Signature

Privacy Practices (HIPAA)

By signing below, I authorize Joseph C. Taub, DPM PA, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

_____

Signature

HIPPA PRIVACY ACT AUTHORIZATION FORM

Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave DETAILED information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.

Primary Phone:_____ Secondary Phone:_____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointment, billing, test results, diagnosis, and procedures in an email.
E-mail address:_____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.
I authorize this facility to speak to the following family members or my personal representative regarding

____All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

____Only the following types of information:_____

The above medical information shall only be released to the following person(s):
1._____ Relationship:_____ Phone number:_____
2._____ Relationship:_____ Phone number:_____
3._____ Relationship:_____ Phone number:_____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

PRINTED NAME:
SIGNATURE:
DATE: