PATIENT REGISTRATION

Welcome to our office! So that we may serve you to the best of our ability, please complete this form as accurately as possible and return it to the receptionist.

Last Name * _____ First Name * _____ MI _____

Address * _____

City * _____ State * _____ Zip Code * _____

Birthday * _____ Age * _____ Social Security * _____

Home Phone * ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____ Ext _____ Email Address * _____

(This email is never shared and is used to give you access to your medical record and statements)

Marital Status * Single / Married / Separated / Divorced / Widowed Gender * Male / Female

Emergency Contact * _____ Relationship * _____

Contact Phone ( ) _____

Medical Doctor * _____ Phone ( ) _____

Address _____ Date Last Seen * _____

_____ _____

Referred by * _____ (example:Doctor/Patient/Insurance/Phone book/Online/Sign)

****Pharmacy (Name and City) _____

Primary Insurance Company * _____

ID # * _____ Group Number * _____

Name of Policy Holder * _____ Date of Birth of Policy Holder * _____

Relationship to Patient * Self / Spouse / Parent / Other Employer of Policy Holder _____

Secondary Insurance Company * _____

ID # * _____ Group Number * _____

Name of Policy Holder * _____ Date of Birth of Policy Holder * _____

Relationship to Patient * Self / Spouse / Parent / Other Employer of Policy Holder _____

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.

I AUTHORIZE RELEASE OF PERTINENT INFORMATION TO ALL MY INSURANCE COMPANIES.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL.

I AUTHORIZE DR. TOLL TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM INSURANCE COMPANIES.

I AUTHORIZE PAYMENT DIRECT TO DR. BRAD A. TOLL

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

WE OBSERVE A STRICT POLICY FOR CANCELLATIONS, RESCHEDULED APPOINTMENTS AND APPOINTMENTS MISSED WITHOUT 24 HOURS NOTICE AND WE RESERVE THE RIGHT TO CHARGE A $35.00 FEE *PLEASE INITIAL* *____*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

Patient (or Guardian) Signature * _____

Patient Name (Please print) * _____ Date _____

Parent or Authorized Representative Name (if applicable) * _____

THANK YOU FOR CHOOSING CROFTON PODIATRY

NEW PATIENT MEDICAL HISTORY

DATE: _____ PATIENT NAME: _____

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

DESCRIBE THE PROBLEM YOU ARE HAVING WITH YOUR FEET:

_____ R L BOTH

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

Medication presently being taken? 1) _____ 4) _____

(Please provide dosage) 2) _____ 5) _____

3) _____ 6) _____

Supplements: (i.e./vitamins) 1) _____ 2) _____

Are you allergic to:(Please indicate your reaction for ones checked yes)

	YES	NO		YES	NO
Antibiotics			Sulfa		
Aspirin			Iodine, Shrimp		
Anesthetics			Tape		
Codeine			Motrin/Naprosyn		
Penicillin			Latex		
Other					

Have you ever had...

	YES	NO		YES	NO
Anemia			Keloid/Thick Scar		
Arthritis(OA or RA)			Kidney or Liver Disease		
Asthma			Osteoporosis		
Blood Clot/Phlebitis			Psychiatric Disorder		
Cancer			Rheum. Fever		
Colitis			Sickle Cell Anemia		
Diabetes	Type 1 or 2		Stroke		
Epilepsy			Thyroid Disease		
Gout			Tuberculosis		
Hearing Problems			Ulcers or Reflux		
Heart Disease			V.D.		
High Blood Pressure			Vision Problems		
High Cholesterol			Other		

Any Medical Conditions in the family? _____

Have you ever had any major injury to the head, back, feet, or legs? If yes, explain: _____

_____

Have you had any surgery? (list) _____

Do you or have you in the past? Smoke Cigarettes _____ Drink Alcohol _____ Take Drugs _____
(recreationally)

Do you participate in any athletic activity or exercise program(if yes what is the activity and how often)?

_____

Job Title:_____ Are you weight bearing at work?_____

2411 Crofton Lane, Suite 25 • Crofton Maryland 21114
Office (410) 721-4505 • Fax (410) 721-2394
www.croftonpodiatry.com

Dear Patient,

1. **INSURANCE** - Patients must present appropriate insurance information at the time of service or the visit will be rescheduled unless a waiver is signed. If your card does not have the appropriate information listed, you will be responsible for your visit.

2. **CO-PAYMENTS AND DEDUCTIBLES** - Co-payments must be paid at the time of service. This is required in the terms of your contract with your insurance company. Any amounts that are applied to the patient's deductible and or co-insurance are due and payable prior to the patient's next visit or within 30 days after notification from your insurance company, whichever comes first. If you are unable to make these payments, arrangements may be made with our billing department prior to your next visit.

3. **NON-COVERED CHARGES** - Please note that in the event of a non-covered charge such as medical devices, OTC medications and supplies we have provided you with flexible payment options. Also, we will submit a claim on your behalf to your insurance for all billable charges.

In an effort to provide you with flexible payment arrangements, we have therefore expanded our payment policy. Payments can be made by cash, check, Visa, Mastercard and Discover.

4. **DEFAULT MAILING OPTION – By default all correspondence, bills and statements are sent via E-MAIL.** If you should like us to mail instead please check-off the following:

□ mail me please.

_____ _____

Patient or Responsible Party **Signature** Date

_____ _____

Patient Name **(Please Print)** Responsible Party **(Please Print)**