Affiliated Footcare Center
www.drgordonfosdick.com
470 Main Street, Middlefield, CT., 06455 (860) 349-8500
15 South Elm Street, Wallingford, CT., 06492 (203) 294-4977

Patient Registration Form

Date:_____

First Name _____ M.____ Last Name _____ Suffix _____

Marital Status
Single / Mar/ Div / Sep/Wid

Sex: Male or Female	**Date of Birth**	**Mobile #**	**Home #**
Email:		**Street Address:**	
City:		**State and Zip:**	
Is it okay to send text reminders? YES or NO		**Is it okay to leave a message? YES or NO**	

Occupation:_____ Employer:_____

Employer Phone#: _____ Employer Address: _____

PCP_____ Phone# _____Date Last Seen_____

Referred by: (circle one)

Family Friend Insurance Plan Internet Search Dr._____

Pharmacy: _____ Phone#: _____

Emergency Contact: _____ Contact# _____

INSURANCE INFORMATION

Primary Policy:		**Member ID#**
Policy Holder Name:	**Relation to Insured**	**Date of Birth**
Secondary Policy:		**Member ID#**
Policy Holder Name:	**Relation to Insured**	**Date of Birth**

AUTHORIZATION AND RELEASE

I hereby authorize payment directly to Dr. Gordon E. Fosdick and/or associates all insurance benefits otherwise payable to me for services rendered. I understand that ultimately, I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I understand any balance outstanding beyond 90 days, from first statement, is subject to an interest rate of 18% APR, cost of collections (50%) and reasonable attorney's fees of thirty-three and one third percent. I also am aware there is a $50.00 NO SHOW fee that is not billable to my insurance, in the event I do not call to cancel or reschedule an appointment. I understand there is a returned check fee of $25.00 for any/all personal checks returned for insufficient funds. I authorize the above noted doctor and/or provider or supplier of services in this office to release any/all information required to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Patient/Guardian Signature:	**Date:**

REASON FOR TODAY'S VISIT- Please indicate the main reason that brought you in.

What is your MAIN foot problem today? _____

_____

Subsequent Issues to discuss? _____

_____

When did it begin? _____ What were you doing? _____

Is the pain □ Constant □ Intermittent?
(explain)_____

Describe the pain: □ Sharp □ Dull □ Aching □Burning □ Throbbing □Other?_____

What causes the problem or makes it worse?_____

Was it caused by an injury? □ Yes □ No (explain if yes)_____

Shoe Size_____ Width_____ **Current Weight_____ Height_____**

Do you wear orthotics? □ Yes □ No Date of last fitting? _____

Have you had any serious illnesses, major injuries, or major surgeries? (If yes explain on back) □ Yes □ No
Are you under a physician's care? □ Yes □ No If yes, for what condition_____

***PERSONAL HEALTH HISTORY**-please check any/all that apply*

Cardiovascular

- Hypertension
- Heart attack
- Stroke
- Chest pain
- Irregular Heartbeat
- Feet swell
- Varicose Veins
- Leg pain when walking
- Restless Leg

Gastrointestinal

- Heartburn
- Acid Reflux/GERD
- Blood in stool
- Ulcer

Vision

- Eyeglasses
- Corrective Lenses
- Impaired sight
- Eye disease
- Legally Blind
- Migraines
- Headaches

Hematologic/Lymphatic

- Bleeding disorders
- Anemia
- Enlarged Nodes

Do you take the following?

- Aspirin dose _____
- Coumadin dose_____

Musculoskeletal

- Arthritis
- Joint pain
- Fractures
- Spinal disorder
- Muscle cramps

Endocrine

- Diabletes Insulin? _____
  How many years? _____
- Kidney Disease

Integumentary (Skin)

- Latex Allergy
- Deformed Nails
- Eczema
- Hives/Rash
- Psoriasis
- Skin Cancer
- Moles

Respiratory

- Asthma
- Emphysema
- COPD
- Wheezing/Shortness of Breath
- Cough phlegm
- Other_____

Nervous System

- Alzheimer's
- Bell's palsy
- Cerebral palsy
- Epilepsy
- Multiple Sclerosis
- Parkinson's
- Numbness in limbs/Weakness
- Vertigo/dizziness
- Gout
- Sciatica

FAMILY MEDICAL HISTORY - *please circle any/all that apply*

Epilepsy	Maternal	Paternal	**Allergies**	Maternal	Paternal
Gout	Maternal	Paternal	**Cancer**	Maternal	Paternal
Hypertension	Maternal	Paternal	**Spinal Disorder**	Maternal	Paternal
Heart Attack	Maternal	Paternal	**Mental Illness**	Maternal	Paternal
Kidney Disease	Maternal	Paternal	**Arthritis**	Maternal	Paternal
Diabetes	Maternal	Paternal			

CURRENT MEDICATIONS and DOSAGE

Medications	Dosage

Medications	Dosage

*****LIST DRUG ALLERGIES: □ CHECK BOX IF YOU HAVE NO KNOWN DRUG ALLERGIES*****

Medication	Reaction	Severity
		□MILD □MODERATE □SEVERE
		□MILD □MODERATE □SEVERE
		□MILD □MODERATE □SEVERE
		□MILD □MODERATE □SEVERE
		□MILD □MODERATE □SEVERE
		□MILD □MODERATE □SEVERE

SMOKING and ALCOHOL STATUS-

Non-Smoker YES	**Smoker YES** **How many packs per day? _____**	**Do you drink Alcohol? YES or NO** **Frequency _____ per day/or week**
Previous Smoker **Years Quit _____**	**Tobacco chewer/dip YES** **How many cans/pouches per day? _____**	**How many drinks in a sitting?**

AFFILIATED FOOT CARE CENTER, LLC

Gordon E. Fosdick, DPM

Diplomate, American Board of Podiatric Surgery, Board Certified in Foot Surgery

Middlefield Office
470 Main St., P.O Box 221
Middlefield, CT 06455
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F (860)349-3081

Wallingford Office
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F (203)294-0045

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices is available for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of Your Health Information: We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.**
2. **Other Uses and Disclosures: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on authorization.**
3. **Your Health Information Rights: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice.**
    a) **You may request restrictions on certain uses and disclosures of your information**
    b) **You may request that you receive your information for us in a certain way**
    c) **You may inspect and copy your medical records**
    d) **You may request an amendment to any record your believe is inaccurate**
    e) **You may request an accounting of disclosures made of your records**
4. **Changes to the Notice: We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.**
5. **Complaints: You may file a complaint to our Privacy Official whose name is above or with federal government as detailed in the Notice. You will not be penalized for filing a complaint.**

Policy has been made available to me for review.

Signature:_____Date_____

Print Name_____

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Authorization to Discuss Medical Information

I hereby authorize you speak to or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results

___Medications ___Lab Tests/Results ____ Summary of Medical Record

___Care Plan ___Other(specify):_____

Indicate Confidential Information: ____Mental Health ___HIV information ____ Alcohol/Drug Information

Information may be disclosed to:

Name: _____

Relationship:_____

Phone:_____

Patient Signature:_____ Date:_____

Relationship to Patient (If signed by personal representative of Patient):_____