Seiter Foot & Ankle Specialists, P.A.
Patient Registration

Name:_____ **Date:**_____

Social Security Number:_____ **Date of Birth:**_____

Gender: ☐ **Male** ☐ **Female**

Address:_____ **City/State/Zip:**_____

Home Phone:_____ **Cell Phone:**_____

Email Address:_____

How may we contact you (check all that apply)? : ☐ **Phone** ☐ **Email** ☐ **SMS (Text Message)**

Employer: _____ **Work Phone:**_____

Marital Status: ☐ **Married** _____ ☐ **Single** ☐ **Divorced** ☐ **Widowed**
(Spouse Name/Phone)

Emergency Contact:_____ **Phone**:_____
(Not living with you)

Referred by: _____

Preferred Pharmacy/Location: _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR
TO BE COMPLETED BY PARENT PRESENT WITH CHILD TODAY

Name:_____ **Relationship:** _____

Address if different from above: _____ **City/State/Zip:**_____

Social Security Number: _____ **DOB:**_____

Phone:_____ **Employer & Employer Phone:** _____

COMPLETE BELOW INSURANCE INFORMATION

PRIMARY COVERAGE:

INS. COMPANY:_____

ID #_____ **GROUP#**_____

If insurance is in spouse/parent name)

Insured Party Name:_____
Insured Party Social:_____
Relationship to Patient:_____
Insured Party DOB:_____

SECONDARY COVERAGE:

INS. COMPANY:_____

ID #_____ **GROUP#**_____

If insurance is in spouse/parent name)

Insured Party Name:_____
Insured Party Social:_____
Relationship to Patient:_____
Insured Party DOB:_____

AGREEMENT AND AUTHORIZATIONS

We are committed to providing you with the best possible care. If you have medical insurance, we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and you understand of our payment policy. You must realize however, that:

1.) Not all services are covered in all contracts. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

2.) Co-payments must be paid at the time of service.

3.) If you have no insurance, payment for service is due at the time of service.

We accept cash, checks, MasterCard, Discover, Visa, & American Express

Initials:_____

I hereby authorize Seiter Foot & Ankle Specialists, P.A. to furnish information to the insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. All professional services rendered are charged to the patient. It is customary to pay for services when rendered. Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their right of exemption under the law of the State of Arkansas or any other state.

Initials:_____

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS

We understand that there are times when you must miss an appointment due to emergences or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due, to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged twenty five dollar ($25) reschedule fee. This fee will need to be paid in full before you can schedule another appointment.

Initials:_____

NOTICE OF PRIVACY PRACTICES and CLINIC POLICIES (Acknowledgment of Receipt)

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Seiter Foot & Ankle Specialists, P.A. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If you have any questions or would like to obtain a revised notice you may contact our clinic at 501-336-0202.

I acknowledge receipt of the Notice of Privacy Practices and Clinic Policies or Seiter Foot & Ankle Specialists, P.A.

CHOOSE ONE →

☐ I request that this authorization never expire.
☐ I request this authorization expire on the following date:_____
(I understand that I must deliver a written revocation to Seiter Foot & Ankle Specialists, P.A. at 1105 Deer Street, Suite, 3, Conway, AR 72032.)

_____ _____

Signature (Patient/Patient Representative) **Date**

MEDICAL HISTORY

Describe in detail the reason for today's visit:
_____
_____
_____

Primary Care Doctor:_____ Date last seen by PCP:_____

Which foot/leg is bothering you? ☐ Left ☐ Right ☐ Both

How long have you had the current problem/condition? _____

What have you done to treat the problem yourself?_____
_____

Are you currently taking any medications? ☐ Yes ☐ No

Medicine List (include over-the counter along with prescriptions) If you have a list already, you may provide it to a staff member so they can photocopy it instead.

_____ _____
_____ _____
_____ _____
_____ _____

Drug allergies: NONE / penicillin / sulfa / codeine / morphine / aspirin
(Circle all that apply) NSAIDS / hydrocodone / iodine / or other:_____

Please list any major surgeries you have had in the past 10 years:
_____
_____
_____

Are you pregnant or nursing? ☐ Yes ☐ No

Height:_____Weight:_____Age:_____

Check any of the following medical conditions you have had:

□ Pneumonia □ Arthritis/Gout □ Nervous Disorder □Stroke □ Epilepsy □ High/Low Blood Pressure
□Diabetes □ Skin Disease □ Varicose Veins □ Keloid/(scar) Formation □ Anemia
□Cancer/Tumors □ Asthma/Hay Fever □ Thrombophlebitis (blood clots)
□ Frequent Colds/Sore Throat □ Kidney Disease □ Bleeding Tendencies □ HIV/AIDS
□ Liver Disease □ Swollen Feet/Ankles □Tuberculosis □Hepatitis
□ Other, Please list_____

Do you have any family history of medical diseases or problems? If yes, please fill in:

Mother's side:_____

Father's side:_____

Sibling:_____

SOCIAL HISTORY:

Tobacco Use: ☐Yes ☐ No If yes, type/amount/ how long _____

Illegal Drug Use: ☐Yes ☐ No If yes, type/amount/ how long _____

Alcohol Use: ☐Yes ☐ No If yes, type/amount/ how long _____

Do you currently, or have you ever had any problems in the following areas:

Constitutional
Fever, Weight Loss/Gain □Yes □ No

Integumentary (Skin) □Yes □ No

Neurological
Headaches □Yes □ No
Migraines □Yes □ No

Seizures □Yes □ No

Psychiatric □Yes □ No

Allergic/Immunologic □Yes □ No

Ears, Nose, Mouth, Throat
Allergies □Yes □ No
Sinus congestion □Yes □ No
Runny Nose □Yes □ No
Post-Nasal Drip □Yes □ No
Chronic Cough □Yes □ No
Dry Throat/Mouth □Yes □ No

Respiratory
Asthma □Yes □ No
Chronic Bronchitis □Yes □ No
Emphysema □Yes □ No

Vascular/Cardiovascular
Diabetes □Yes □ No
Heart Pain □Yes □ No
High Blood Pressure □Yes □ No
Vascular Disease □Yes □ No

Gastrointestinal
Diarrhea □Yes □ No
Constipation □Yes □ No

Bones/Joints/Muscles
Rheumatoid Arthritis □Yes □ No
Muscle Pain □Yes □ No
Joint Pain □Yes □ No

Lymphatic/Hematologic
Anemia □Yes □ No

Endocrine
Thyroid/Other Glands □Yes □ No

If you answered Yes to any of the above or have/had a condition not listed, please explain:

_____

_____

I certify the above is accurate and true to the best of my knowledge.

Signature:_____ **Date:**_____
(Patient or parent / guardian if patient is a minor)