TLC FAMILY FOOTCARE

Dr. Paulo Yen

REGISTRATION FORM

(Please Print)

Today's Date:	Family Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's Relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TLC Family Footcare or insurance company to release any information required to process my claims. I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Patient/Guardian Signature _____ Date _____

WELCOME TO TLC FAMILY FOOTCARE

we treat your feet with tender loving care

Please fill out this History Form regarding your health to the best of your knowledge. This will aid us in understanding your health prior to any treatment. Thank You.

Patient Name:_____ Birthdate: _____ Age:_____
Last First M.I.

Family Physician_____ Last Date Seen:_____

HISTORY OF PRESENT ILLNESS

Chief Complaint: _____

When did it start? _____ What caused it? _____

Where does it hurt? _____

What aggravates it? _____

Any previous treatment or tests and by whom? _____

Has this same condition occurred in the past and how long ago?_____

PAST MEDICAL HISTORY. Previous hospitalizations, illnesses and surgeries. Please include dates.

1._____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

SOCIAL HISTORY

Do you drink alcoholic beverages? ___ Never ___ Rarely ___ Moderate ___ Daily
Have you been treated for alcoholism? ___ Yes ___ No How long ago? _____
Do you use tobacco products? ___ No ___ Yes What kind? _____
How long have you been smoking? _____ How many packs per day? _____
If you quit smoking tobacco, when did you quit? _____ How much did you smoked? _____
and for how long? _____
Do you use any "illicit" or "street drugs"? ___No ___ Yes Type and frequency: _____
Do you drink caffeinated beverages? ___ No If yes, what kind and how often? _____

FAMILY HYSTORY

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Grandparents:			
Siblings:			

ALLERGIES TO MEDICATIONS AND FOODS:

_____

_____

REVIEW OF SYSTEMS. Please place a check mark next to the condition that you currently have or had it in the past.

CARDIOVASCULAR

__ High blood pressure
__ Heart disease
__ Congestive heart failure
__ Stroke
__ Chest pain
__ Heart murmur
__ Mitral valve prolapse
__ Shortness of breath during exertion
__ Swelling of feet and ankle
__ Heart attack
__ Pain in the calf muscles
__ Deep venous thrombosis
__ Phlebitis

RESPIRATORY

__ Tuberculosis
__ Pneumonia
__ Asthma
__ Emphysema
__ Chronic Obstructive Pulmonary Disease
__ Lung cancer

GASTROINTESTINAL

__ Crohn's disease
__ Gastric reflux
__ Hiatal hernia
__ Peptic or duodenal ulcer
__ Gall stones
__ Diverticulitis
__ Blood in the stool
__ Hepatitis, type _____
__ Cirrhosis of the liver

GENITOURINARY

__ Kidney stones
__ Blood in the urine
__ Incontinence
__ Excessive urination
__ Venereal disease
__ Kidney failure

EAR, NOSE, THROAT, MOUTH AND EYES

__ Decreased hearing
__ Ear infection
__ Vertigo
__ Sinusitis
__ Loss of sense of smell
__ Nasal polyps
__ Sore throat
__ Dentures
__ Teeth and gum disease
__ Wear eyeglasses or contacts
__ Glaucoma
__ Cataracts

MUSCULOSKELETAL

__ Fibromyalgia
__ Rheumatoid arthritis
__ Osteoarthritis
__ Gout
__ Lower back pain
__ Herniated disk
__ Muscle weakness
__ Difficulty in walking

NEUROLOGICAL

__ Seizures or convulsions
__ Paralysis
__ Cerebral palsy
__ Neuropathy
__ Polio
__ Reflex sympathetic dystrophy
__ Parkinson's disease

DERMATOLOGY

__ Psoriasis
__ Eczema
__ Abnormal scarring
__ Changes in the nails
__ Hair loss
__ Abnormal skin growth
__ Dry skin
__ Excessive sweating of the feet

HEAD AND NECK

__ Migraine headaches
__ Head injury

ENDOCRINE/HEMATOLOGY

__ Diabetes mellitus
how many years _____
__ Thyroid disease
__ Excessive thirst
__ Anorexia
__ Anemia
__ Prolonged bleeding
__ Past history of blood transfusion
__ Recent weight gain or loss

OB/GY

Are you pregnant? _____
If yes, How many months? _____
Gravida _____ Para _____
Miscarriage _____

IMMUNOLOGIC

Do you have AIDS? _____
Kaposis sarcoma _____
Recurrent infections? _____
Where? _____
Do you have any communicable disease that we need to know about?
_____, What kind? _____
_____

PSYCHIATRIC

__ Depression
__ Anxiety attacks
__ Bipolar
Any other mental illness? _____
_____

CURRENT MEDICATIONS

_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient signature: _____ Date: _____ Nurse's initials: _____

TLC FAMILY FOOTCARE

ACKNOWLEDGMENT 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 chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

May we leave a message in your answering machine regarding your medical information and laboratory results?

_____ Yes _____ No Initials_____

Who else may we share your medical information with?

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature Date

TLC Family Footcare
OFFICE POLICIES

PERSONAL PROPERTY

It is understood and agreed that the office shall not be liable for the loss or damage to any money or other valuables, and shall not be liable for the loss of damage to any other personal property, even though it is deposited with the office for safekeeping.

_____ **INITIAL**

CONSENT FOR TESTING BLOOD

To protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood while I am a patient. For example, if an employee is stuck by a needle or other sharp instrument, or sustains a scalpel injury while caring for me (or my dependent) my blood will be tested. I further understand that my blood will not be routinely tested for these diseases and that the results of any testing will be kept confidential.

_____ **INITIAL**

APPOINTMENTS

Rescheduling and Cancellations: In order to reschedule or cancel an appointment, please do so at least 24 hours before appointment time (exceptions may be made upon reason) as a courtesy to make it possible for other patients to be seen. If you are more than 10 minutes late for an appointment it may have to be rescheduled.

_____ **INITIAL**

NO SHOWS: If you fail to show for an appointment that has been scheduled, it is considered a NO SHOW. There will be a $30.00 fee for missed office visit or a $60.00 fee for missed procedure.

After **3** NO SHOWS, you may be terminated from our practice.

_____ **INITIAL**

BILLING AND COLLECTION POLICY

Payment is required for services at the time they are rendered unless prior arrangements have been made. As a courtesy, we will file your health insurance for you and you will be responsible for any amount not paid by them to include but not limited to copayments, coinsurance or deductibles as stated by your carrier.

There will be a $25.00 fee for any returned checks.

In the event your account becomes delinquent, you will be responsible for added collection fees not to exceed 35% of the outstanding balance, as well as, any potential attorney fees.

Your signature below signifies your understanding and willingness to comply with these policies.

Patient/Guarantor's Signature_____ **Date**_____