Podiatry Registration and History

Patient Name_____ **Preferred Pharmacy**_____
Primary Care Dr_____ **Date Last Seen**_____

Podiatric History

What problem are we seeing you for today?_____
How long have you noticed this problem?_____ Approximate Date of Injury?_____
List previous treatments for this problem:_____
Have you ever seen a Podiatrist before? Y N For what problem?_____

Medical History

Weight_____ Height_____ Do you Smoke? Packs per day:_____
Age_____ Shoe Size_____ Do you drink Alcohol? How often?_____

Review of Systems: If you have problems with any of the following health conditions, please circle them.

☐ **CHECK HERE IF NONE OF THE BELOW**

- ●Eyes:
  Cataracts / Glaucoma / Mac Degeneration / Retinopathy
- ●Ear, Nose, or Throat
- ●Heart Disease:
  Atrial Fibrillation / Congestive Heart Failure/
  History of chest pain / History of heart attack /
  Ischemic / Pacemaker / Stents / Valve Disorder
- ●Respiratory Disease:
  Asthma / COPD / Emphysema / Tuberculosis
- ●Gastrointestinal:
  Crohns / IBS / Ulcerative Colitis / Gastric Reflux / Ulcers
- ●Liver Disease:
  Cirrhosis / Failure / Hepatitis / Jaundice
- ●Kidney problems
- ●High blood pressure
- ●High cholesterol
- ●Diabetes:
  Type 1 / Type 2 / PreDiabetic Last A1C:_____
- ●Thyroid:
  Hyperthyroidism / Low thyroid / thyroid removed
- ●Peripheral Neuropathy (non-diabetic)
- ●Psychiatric care:
  Anxiety / Depression /
  Alzheimers / Dementia / Memory loss
- ●Arthritis
  Gout / Osteoarthritis / Psoriasis / Rheumatoid
- ●Artificial Joints:_____
- ●Back problems
- ●Blood Thinner
- ●Cancer
- ●Circulatory:
  Anemia / Bleeding Disorder / Leg Ulcerations / Phlebitis
  Swelling in feet / Varicose veins
- ●Fibromyalgia
- ●Foot/leg cramps
- ●Gout
- ●Infection (current):_____
- ●Low blood pressure
- ●Neurological
  Cerebral Palsy / MS / Parkinsons
- ●Stroke

Other:_____

Medications (or give written list to front-desk)
☐ **CHECK HERE IF NO MEDICATIONS**

Medication Name	*Dosage/Strength*

Allergies? *Please circle*
☐ **CHECK HERE IF NO ALLERGIES**

Adhesives,Tape
Codeine
Coumadin/Warfarin
Demerol/Meperidine
Iodine
Local Anesthetic
Penicillin
Sulfa
Shellfish
Vicodin/Hydrocodone
Other:_____

Major surgeries/hospitalizations you have had:_____
_____
Other applicable medical information:_____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet with my consent.

Responsible Party Signature_____ **Date**_____

Hoyal Podiatry Policies and Procedures Agreement

updated 01/01/2025

HIPAA PRIVACY POLICY

I have received or been offered a copy of James I Hoyal, DPM's Notice of Privacy Practices. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

MEDICAL TREATMENT POLICIES

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor or staff. I authorize the doctor to retrieve a list of my current medications in order to check for any possible interactions with my treatment.

INSURANCE GUIDELINES

I understand that my insurance policy is a contract between myself and my insurance carrier. It is my responsibility to provide correct/updated insurance information to the provider. The medical office is a third party that bills the insurance as a courtesy to me. I authorize my insurance benefits be paid directly to the physician. I understand that there are numerous different insurance plans and that they make changes to their benefits frequently. While the medical staff will do their best to assist with insurance matters, I understand that it is ultimately my responsibility to know what my insurance covers. The doctor will assess and offer treatment based on the best medical options available, but if I have a question about coverage I have the responsibility to contact the insurance before accepting treatment. If my insurance requires a referral it is my responsibility to obtain that before date of service. I authorize Hoyal Podiatry to both obtain and release any information required in order to process my claims.

FINANCIAL AGREEMENT

- ***Missed appointments and same-day cancellations are subject to a $50 charge.*** This charge must be paid before scheduling another appointment. Because my appointment time is reserved specifically for me and not double booked, it is my responsibility to give 24 hours notice if I will not be able to keep my appointment so that the office has time to fill my timeslot.
- It is my responsibility to understand the terms of my contract with my insurance company in regard to copays, deductibles, and benefit amounts, which may be collected at the time of service. If my insurance company is delinquent on paying for my treatment, the medical office may request payment from me and will refund me promptly once my insurance pays.

Payment in full is due within thirty (30) days from the date of service unless the office has agreed to a payment plan. Interest accrues on all past-due amounts at a rate of 8% per month. I understand and agree that if payment in full is not made as required or any action is needed to otherwise enforce this agreement, then in addition to all other amounts that may be due or remedy that may be sought, I will be required to pay a collection fee of up to 40% of the principal amount (as allowed by §12-1-11 of the Utah Code Annotated). I further agree to pay all other costs of collection and/or enforcement including but not limited to court costs, reasonable attorney fees, and interest (both pre- and post-judgment). Any interest due hereunder shall be calculated at 18% per annum and may compound as frequently as daily. The terms of this agreement apply to any present or future expenses incurred by me or by any individual for whom I have financial responsibility. Any payments made may be applied to interest payments first.

By signing below I am confirming that I authorize treatment and understand and agree to all the office policies.

Patient or Responsible Party Signature *Date*

HOYAL PODIATRY REGISTRATION FORM

PATIENT INFORMATION

Other family members seen here, if any:

I heard about Hoyal Podiatry from:
❑ Doctor:_____ ❑ Insurance ❑ Family/Friend:_____ ❑ Drive-by ❑ Internet ❑ Other_____

Legal name: First Middle Last	**Preferred name**	**Marital status** (circle one) Single / Mar / Div / Sep / Wid

Date of Birth / /	**Gender** ❑ M ❑ F	**Social security number:** **(required for Medicare & Tricare)**	**Email: (for the patient portal)**

Street address City State Zip code

Appointment confirmations require a response: My preferred # is: (circle one) Cell Home Work Cell: Home: Work:	**Race** (circle one): White Asian Black/AfricanAmerican Multi-Race PacificIslander AmericanIndian/AlaskaNative NativeHawaiian Refuse to Report **Ethnicity** (circle one): Hispanic/Latino Non-Hispanic/Latino Refuse to Report

RESPONSIBLE PARTY INFORMATION

(**MUST be here to sign papers** - *only fill this in if the patient is a minor or otherwise unable to sign for themselves*)

Person responsible for bill:	Birth date: / /	Address (if different than patient):	Phone Number:

Relationship to patient:

INSURANCE INFORMATION

Name of **Primary** insurance:	Subscriber Name:
Subscriber DOB:	Subscriber Place of Employment:
Name of **Secondary** insurance (if applicable):	Subscriber Name:
Subscriber DOB:	Subscriber Place of Employment:

RELEASE OF INFORMATION

I authorize the release of full medical information to the following individuals. I understand that Hoyal Podiatry is not held responsible for any misuse of this information by the approved individuals:

Emergency contact:_____ Phone:_____ Relation to Pt:_____
Additional Contact:_____ Phone:_____ Relation to Pt:_____

CONSENT

The above information is true to the best of my knowledge. I hereby consent to being contacted by telephone or text at any phone number (including but not limited to wireless/cellular phone numbers) provided to Hoyal Podiatry by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Hoyal Podiatry or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. I understand that email or texts may not be secure. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

Patient or Responsible Party signature: *Date*