Hoyal Podiatry

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Other family members seen here, if any:

I heard about Hoyal Podiatry from:
❑ Doctor:_____ ❑ Insurance ❑ Hospital ❑ Family ❑ Friend:_____
❑ Drive-by ❑ Yellow Pages ❑ 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**	**Email (to allow you access to your medical record online)**

Street address City State Zip code

I prefer my appointments to be confirmed by:
❑ Call ❑ Email ❑ Text to cell#_____

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

Phone numbers:
My preferred # is: (circle one) Cell Home Work

Cell:

Home:

Work:

RESPONSIBLE PARTY INFORMATION

(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

(You do not need to fill this out if you have given your cards to the front desk be copied)

Name of **primary** insurance:

Subscriber's name:	Birth date: / /	Policy number:	Insurance phone #:	Insurance address:

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

Name of **secondary** insurance (if applicable):

Subscriber's name:	Birth date: / /	Policy number:	Insurance phone #:	Insurance address:

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:	Phone number:

The above information is true to the best of my knowledge. I consent to be contacted by Hoyal Podiatry or any of its affiliates via any contact means I have provided or that have been provided by someone acting on my behalf. Some contact means may results in data charges. I understand that I am financially responsible for any balances incurred by me or any individual I have legal responsibility for.

Patient or Responsible Party signature: *Date*

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.

- ●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:
  Alzheimers / Dementia or memory loss / Depression
- ●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)

Medication Name	*Dosage/Strength*

Allergies? *Please circle*

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

Major surgeries you have had:_____
Other Hospitalizations:_____
Are you now, or have you been, under any other doctor's care for any reason over the past two years? Y N
If yes, please explain_____

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

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. 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. Due to the large number of different insurance companies and their frequent changes, it is very difficult to keep track of each insurance plan's frequent changes in coverage and benefits. 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 may be subject to a $25 charge. Because my appointment time is reserved specifically for me, it is my responsibility to give 24 hours notice if I will not be able to keep my appointment.

It is my responsibility to understand the terms of my contract with my insurance company in regard to copays, deductibles, and benefit amounts. Copays and deductibles will be collected at the time of service from the medical office. If my insurance company is delinquent on paying for my treatment, the medical office may request payment from me and will refund me once the insurance pays.

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. If I am unable to pay the full balance on my account, I will set up a monthly payment plan with the office. I agree that interest will accrue on all past-due amounts at a rate of 1.5% per month. Any balance not actively being paid off may be sent to a debt collections agency. The medical office will make every effort to contact me before this happens. In the event the account is turned over to Collections, I understand that I am responsible for all interest, court costs, attorney costs, a $6.25 certified mail charge, and a collection fee of up to 33% of the principal balance as allowed by Utah Code Annotated, sec. 12-1-11. 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.

Patient or Responsible Party Signature *Date*