BENENATI FOOT AND ANKLE CARE CENTERS
PATIENT REGISTRATION FORMS

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____

BIRTHDATE:____/____/_____ Patient Legal Sex: *MALE / FEMALE* Patient SSN: _____

MARITAL STATUS: *SINGLE / MARRIED / DIVORCED / WIDOWED / SEPARATED*

PATIENT ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

HOME PHONE: (_____)_____ CELL: (_____)_____ WORK: (_____)_____

EMAIL: _____

PREFERRED METHOD FOR APPOINTMENT REMINDERS: HOME CELL TEXT EMAIL

GUARANTOR INFORMATION *(IF PATIENT IS A MINOR)*

First Name:_____Last Name: _____ Middle Initial: _____

Birthdate: _____/_____/_____ Relationship to patient: _____ Phone: (_____)_____

RESPONSIBLE PARTY *(IF DIFFERENT FROM GUARANTOR)*

First Name: _____ Last Name: _____ Middle Initial: ____

BILLING ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

How were you referred to our Office? Doctor / Internet / Sign / Family or Friend / Other: _____

Primary Care Physician: _____

PCP Address: _____City: _____State:_____ Zip: _____

PCP Phone: (_____)_____ Fax: (_____)_____ Hospital Affiliation:_____

Are you diabetic? YES NO Who treats your Diabetes?_____

BENENATI FOOT AND ANKLE CARE CENTERS
INSURANCE INFORMATION

Is this visit related to a Work or Auto accident? *Work* *Auto* *No*

If Work or Auto, do you have an open claim for the accident? *Yes* *No*

Does your Insurance require your labs be sent to a specific lab? No Yes

(Please circle below)

Quest Labs *Ascension (JVHL)* *LabCorp* *Beaumont*

Henry Ford *Other:*_____

PRIMARY INSURANCE:

Insurance Name:_____ Customer Service #: (_____)_____

Subscriber Name: _____ Subscriber Birthdate: ____/_____/_____

Contract #: _____ Group #:_____

Patient Relationship to Subscriber: Self / Spouse / Child / Other: _____

SECONDARY INSURANCE:

Insurance Name:_____ Customer Service #: (_____)_____

Subscriber Name: _____ Subscriber Birthdate: ____/_____/_____

Contract #: _____ Group #:_____

Patient Relationship to Subscriber: Self / Spouse / Child / Other: _____

OVERALL HEALTH: GOOD / FAIR / POOR **HEIGHT: _____** **WEIGHT: _____**

Please Circle any of the following that apply:

Constitutional	**Eyes**	**Ear, Nose & Throat**
Fever	Blurred/Double Vision	Tinnitus
Weight Loss	Cataracts	Nose Bleeds
Lethargy	Glasses and/or Contacts	Nasal Congestion
		Sore Throat
		Difficulty Swallowing
Respiratory	**Cardiovascular**	**Skin**
Chronic Cough	Shortness of Breath	Itching
Wheezing	Chest Pain (Angina)	Lumps
Emphysema	Heart Palpitations	Rash
Cough Blood	Heart Attack	Dry Skin
Productive Cough	Stroke	Calluses
Asthma	Cold Extremities	Erythema
	Calf Pain	Fungal Nails
	High Blood Pressure (Hypertension)	Ingrown Toenails
	Lower Extremity Swelling	Open Lesions
Neurologic	**Musculoskeletal**	**Gastrointestinal**
Dizziness	Limited Range of Motion	Heartburn
Memory Loss	Pain (musculoskeletal)	Diarrhea
Weakness	Limited Strength	Food Intolerance
Fainting	Foot Deformity	Nausea
Headache	Arthritis	Blood in Stool
Numbness		Blood in Vomit
Tingling		Loss of Appetite
		Constipation
		Change in Stool
		Mucus in Stool
		Pain (Gastro)
Genitourinary	**Hematologic/ Lymphatic**	**Endocrine**
Urinary Frequency	Easy Bruising	Night Sweats
Abnormal urine color	Blood Thinners	Thyroid Disease
Unable to fully Empty Bladder	Anemia	Diabetes
Blood in Urine	Lymph Node Enlargement	
Painful Urination	Blood abnormalities	
On Hemodialysis		
Incontinence		
Awaken to Urinate		

WHAT CONCERNS DO YOU HAVE REGARDING YOUR FEET?

_____

_____

_____

PAST SURGICAL HISTORY *(PLEASE LIST TYPE OF SURGERY AND YEAR):*

_____

_____

_____

FAMILY HISTORY:

Diabetes Arthritis Stroke Hypertension Bleeding Disorders

Heart conditions Respiratory Disorders Foot Problems Cancer: _____

Other: _____

Tobacco Use:

Previous Smoker

Chew Tobacco

Smoke Cigarettes

E-Cigarettes/Vape

Alcohol Use:

Never Alcohol Use

Social Alcohol Use

Heavy Alcohol Use

Previous Alcohol Use

Drug Use:

Illegal Drug Use

Previous Drug Abuse

Current or Previous Opioid Abuse

No Drug Use

PAST MEDICAL HISTORY:

Hepatitis hypertension asthma anemia arthritis

Cancer Diabetes DVT Bleeding tendencies cholesterol

emphysema gout Glaucoma hypoglycemia

heart/ circulation trouble epilepsy HIV/AIDS Kidney Disease

liver disease leg cramps nervousness stroke tumors

Tuberculosis thyroid disease ulcers varicose veins

Other: _____

ALLERGIES: **Do you have allergies to any medications?**

Penicillin	Sulfa	Codeine	Demerol	Aspirin	Novocain
Tetracycline	Darvon	Cipro	Seconal	Tetanus	Anesthetics
Antihistamines	Eggs	Keflex	Other_____		

ARE YOU ALLERGIC TO LATEX PRODUCTS: *YES* *NO*

Have you received a flu shot in the last year?

NO *YES - Date:_____*

Have you received a pneumonia vaccine in the last 5 years? *(Patients age 65+ only)*

NO *Yes – Date:_____*

PHARMACY

PHARMACY NAME:_____ **PHONE: (_____)_____**

ADDRESS: _____ **CITY:_____**

CROSS ROADS: _____

CURRENT MEDICATIONS: Please List all prescription medications you are taking, include dosage and frequency. (Insulin, inhalers and patches should be included):

_____

_____

_____

_____

ARE YOU ON BLOOD THINNERS? *YES* *NO*

NON-Prescription medications you take routinely *(ex. Vitamins, supplements, etc.)-*

_____

_____

_____

_____

INFORMATION / FINANCIAL RESPONSIBILITY / ASSINGMENT AND RELEASE

How may I pay?

We accept payment by Cash, Check, Visa, MasterCard, Discover, American Express & Care Credit either in person, by mail or over the phone.

Do I need a referral or pre-certification?

If your insurance plan requires a referral authorization from your primary care physician or pre-certification from your insurance, you are responsible for contacting your PCP or insurance company to be sure it has been obtained. If we have not received an authorization prior to your arrival at the office, your appointment may be rescheduled or you can choose to pay out of pocket the day the services are rendered. If you are seen without a valid authorization on file and your insurance denies the claim, you will be responsible for the full charge amount, no discounts.

Which plans do you contract with?

Benenati Foot & Ankle Care Centers accepts most major insurance plans. However, it is always best that you check with your insurance that you have chosen to see a provider in-network with your insurance. It is also your responsibility to let our office know if any labs are required by your insurance to be sent to a specific lab.

Why do I have to pay my co-pay and/or deductible?

When you signed up with your insurance carrier, you basically signed a contract which stipulates that you are obligated to pay your copay and/or deductible in certain instances. That usually means that you are required to pay for office visits, including follow-up examinations, outpatient surgical procedures done in our office, etc. Payment for all copays are expected at the time services are rendered, a $15 fee will be charged for all copays not paid when services are rendered. Collections upfront reduce administrative costs and become a savings to you, the patient.

What is my financial responsibility?

Our office will submit your claims to your insurance company as a courtesy service to you. It is your responsibility to know what services you insurance plan covers; we take no responsibility to know what your plan covers. Services that we render that are not covered by your insurance company, including lab fees, DME and surgical procedures, are your responsibility. Please be sure to notify us if your insurance requires labs to be sent to a specific lab company to avoid excessive costs to yourself. We emphasize, as your health care provider, that our relationship is with you and NOT with your insurance company. Patients without insurance will be responsible for payment in full prior to treatment being rendered. Please contact the office for Medical Records and fees for personal records requests.

What if I miss my appointment?

We understand there may be times we forget or something happens that we cannot make a scheduled appointment. Please understand that repeat offenders of this will be charged a $55 fee for all appointments that have NOT been cancelled/rescheduled within 24 hours of the appointment. 3 or more no shows or continually late to a scheduled appointment may be grounds for dismissal from our care.

What if my child needs to see the physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. If a procedure is to be performed, a parent or legal guardian must be present to sign the consent form. This cannot be any other adult or authorized representative for the patient. If a minor is going to be accompanied by someone over 18 that is not a parent or legal guardian, there must be a written note from the parent or legal guardian giving the authorized adult permission to bring the minor to the appointment.

Work Injuries:

If you have suffered a work injury and the claim will be submitted to a Workman's Comp Plan, it is your responsibility to provide our office with the name of the adjuster and their phone #, a claim number, date of injury, and claim address. This information must be given to our office prior to your appointment so we can verify that the claim is open and billable and what body parts are covered under that claim.

I have read, understand and accept the above statements. I certify that I (or my dependents) have insurance and assign payment directly to Benenati Foot & Ankle Care Centers, all insurance benefits, if any, otherwise billable to me for services rendered. I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to, copays, deductibles, co-insurance and non-covered services. I consent to having my blood drawn and being tested for Hepatitis and HIV if doctor and/ or staff are exposed to my blood and/or fluids. I hereby authorize the doctors to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims submissions. Outstanding balances of 90 days past due may be referred to a collection agency, and such accounts may be reported to a national credit agency. I agree that I may be charged reasonable collection fees and attorney fees if the office is forced to refer my past due account to collection and/ or an attorney.

Print Patient Name:_____

Patient Signature: _____ **Date:** _____

(For Minors) Parent of Legal Guardian Signature:_____