

# BENENATI FOOT & ANKLE CARE CENTERS

## NEW PATIENT REGISTRATION FORM

### Please Complete the Following Information

Patient's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Patient's employer \_\_\_\_\_ Telephone # \_\_\_\_\_

Emergency contact, not at your address, and relationship: \_\_\_\_\_ Telephone # \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone # \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

### Insurance Information:

Type of Insurance: \_\_\_\_\_ Subscriber's name: \_\_\_\_\_ Subscriber date of birth \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ Subscriber's employer: \_\_\_\_\_ Telephone: # \_\_\_\_\_

Person responsible for bill and relationship: \_\_\_\_\_

### Medical History:

Known allergies to medication: \_\_\_\_\_

Current medications (please list name and dosage) \_\_\_\_\_

What is your foot problem? \_\_\_\_\_

Please circle Yes or No:

Heart Disease or Heart Murmurs	Yes No	Heart Attack	Yes No
Hypertension (high blood pressure)	Yes No	Cerebrovascular Accident (Stroke)	Yes No
Pulmonary Disease (Lung)	Yes No	Seizures	Yes No
Neurological Disease	Yes No	Kidney Disease	Yes No
Diabetes (sugar)	Yes No	Liver Disease	Yes No
Bleeding Tendency	Yes No	Smoking (how much? _____)	Yes No
Substance Abuse (marijuana, alcohol, cocaine etc)	Yes No	Infectious Disease (Hepatitis, HIV, etc)	Yes No

Have you received a copy of the Notice of Privacy Act (see attached) YES or NO?

Will you allow us to contact you by mail or phone for example: Appointment Reminders or Communiqués from this office? YES or NO

If No, please contact our Privacy Officer by mail.

I hereby authorize payment for all service to be paid directly to Dr. Anthony V. Benenati, DPM PC. I understand that I am responsible for all deductibles, co-pays and all services not covered by my insurance company. I also authorize Dr. Benenati to release my medical records to the insurance company regarding pre-authorization or claim payment. I understand that if my insurance company requires me to obtain a referral to see Dr. Benenati, and I do not obtain one prior to my visit, I will be responsible for all charges. I do consent to having my blood drawn and being tested for hepatitis and HIV if Dr. Benenati and/or his staff are exposed to my blood and/or body fluids.

Signature of patient \_\_\_\_\_ Date: \_\_\_\_\_

And/or guardian/ foster (we do require proof of guardian/ foster care giver)

We are pleased you chose to be seen in our office.