PATIENT REGISTRATION FORM
PLEASE PRINT BOTH SIDES OF FORM

Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

PATIENT NAME_____ **PHONE**:_____

ADDRESS_____ **CITY**_____ **STATE ZIP**_____

AGE_____ **DATE OF BIRTH**_____ **PATIENTS SOCIAL SECURITY #**_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE**_____

NAME & ADDRESS OF PERSON TO BE BILLED_____

HOW DID YOU HEAR ABOUT US?_____ **FAMILY DOCTOR**_____

NAME & ADDRESS OF EMPLOYER_____

EMPLOYER PHONE_____ **OCCUPATION**_____

WHAT IS YOUR FOOT PROBLEM?_____ **SHOE SIZE**_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

BASIC HEALTH INFORMATION

The following information is necessary for your care and treatment. Please answer completely.

1. **IS YOUR FOOT PROBLEM THE RESULT OF AN INJURY** ☐ **YES** ☐ **NO**

   IF YES, DATE OF INJURY_____ **WHERE DID IT OCCUR?**_____

2. **ARE YOU IN GOOD HEALTH?** ☐ **YES** ☐ **NO**

3. **ARE YOU NOW OR HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST 2 YEARS?** ☐ **YES** ☐ **NO**

4. **DO YOU HAVE ANY BLEEDING PROBLEMS?** ☐ **YES** ☐ **NO**

5. **ARE YOU OR ANY OF YOUR FAMILY MEMBERS A DIABETIC?** ☐ **YES** ☐ **NO**

6. **DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS?** ☐ **YES** ☐ **NO**

7. **ANY PROBLEMS WITH MEDICATIONS OR ANESTHESIA?** ☐ **YES** ☐ **NO**

   IF YES, PLEASE EXPLAIN_____

8. **HAVE YOU EVER BEEN TREATED FOR HEART TROUBLE, ASTHMA, EPILEPSY, RHEUMATIC FEVER, KIDNEY OR LIVER PROBLEMS OR CIRCULATION (VASCULAR)?** ☐ **YES** ☐ **NO**

9. **HAVE YOU HAD ANY SERIOUS ILLNESS OR SURGERIES?** ☐ **YES** ☐ **NO**

10. **HEIGHT**_____ **WEIGHT** _____

INSURANCE INFORMATION

PLEASE ANSWER ALL QUESTIONS COMPLETELY SO THAT WE MAY PROPERLY FILE YOUR CLAIMS

DO YOU HAVE HEALTH INSURANCE? _____YES _____NO MORE THAN ONE_____

NAME OF PRIMARY INSURED_____SOCIAL SECURITY #_____

INSURED'S ADDRESS_____PHONE_____

INSURED'S EMPLOYER_____PHONE_____

EMPLOYER'S ADDRESS_____

INSURED'S DATE OF BIRTH_____NAME OF INSURANCE CO._____

POLICY_____GROUP #_____EFFECTIVE DATE_____

I HEREBY GIVE MY PERMISSION TO MOLLY S. JUDGE, D.P.M. TO DIAGNOSE AND TREAT MY MEDICAL CONDITION AS MAY BE DEEMED NECESSARY.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim and request payment of Medicare/Insurance benefits either to myself or to the party who accepts assignment below.

X_____DATE_____

I authorize payment of benefits to undersigned physician or supplier for services rendered.

X_____DATE_____

COMPLETE IF APPLICABLE:

The responsibility for payment of services rendered to minor children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Name of Minor Child_____

Signature_____DATE_____

North West Ohio Foot & Ankle Institute, LLC

Molly Judge, DPM

530 Washington Street Port Clinton, Ohio 43452

5164 Monroe Street Toledo, Ohio 43623

Past Medical History

Check the answer Yes or No Comments

	Yes Or NO	Comments
High blood pressure	Yes☐ No☐	_____
Heart Disease	Yes☐ No☐	_____
Heart attack	Yes☐ No☐	_____
Diabetes	Yes☐ No☐	_____
Thyroid disease	Yes☐ No☐	_____
Kidney disease	Yes☐ No☐	_____
Liver disease	Yes☐ No☐	_____
Lung disease	Yes☐ No☐	_____
Melanoma	Yes☐ No☐	_____
Cancer of any kind	Yes☐ No☐	_____
Specify cancer type and history of treatment:	Yes☐ No☐	_____

_____

_____

_____

Arthritis; any form	Yes☐ No☐	_____
Broken bones	Yes☐ No☐	_____
Neck or back injury	Yes☐ No☐	_____
Other medical conditions	Yes☐ No☐	_____

Please add your first, middle initial and last name to each sheet in case of separation

_____

Medication History

*Enter all drugs taken daily including over the counter and herbal medications

Start Date	Drug Name	Dose Frequency

Allergy experience: No Known Drug Reaction (NKDA)

Drug Reaction (rash etc…)	Year

Surgical History

Year	Surgeon	Hospital

Explain complications from any of the above procedures:

_____

_____

Please add your first, middle initial and last name to each sheet in case of separation

_____

Family History

Relatives on mother's side:

_____

Relatives on father's side:

_____

Review of Systems

Please indicate if you have had a problem with any of the following:

Year	**comment**
Head, ear, eyes, nose or throat:	_____
Lungs:	_____
Heart:	_____
Vascular / Artery or vein problem:	_____
Gastrointestinal / Stomach:	_____
Genito urinary / Kidney, Prostate:	_____
Muscle weakness:	_____
Neurologic condition:	_____
Psychological or social issues:	_____
Trauma / Motor vehicle accidents:	_____
Glands /Thyroid, diabetes:	_____
Height Weight Shoe size	_____

Please add your first, middle initial and last name to each sheet in case of separation

_____

HIPPA COMPLIANCE FORM:
Individual Patient's Authorization Sheet

Molly S. Judge
DPM, FACFAS
Board Certified: Reconstructive Rear Foot & Ankle Surgery

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose any protected health information as described in section 2 below.

I give this authorization voluntarily.

Individual Patient's Name: _____

Patient's Address: _____

Patient's Telephone Numb **er:(** **)** _____

Patient's Social Security Number: _____

2. THE USE AND / OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information that you are authorizing to be used and/or disclosed and/or disclosed my protected health information as described in section 2 below. I give this authorization voluntarily. (Medical Records, laboratory results, test results, etc. Please specify otherwise if you prefer: _____
_____
_____

Name the people and/or organizations (or other kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected health information described above. Any physician, physical therapist or chiropractor treating you, authorized family members or guardians and insurance companies associated to you: _____
_____
_____

Name the people and/or organizations (or the kinds of people and/or organizations) that are authorizing to receive and use your protected health information. _____
_____
_____

PRIVACY PRACTICES ACKNOWLEGEMENT

ACKNOWLEGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____

Today's Date: _____

PAYMENT POLICY INFORMATION

Please present your insurance card to the receptionist upon arrival to our office. As a courtesy your medical services will be billed directly to the insurance carrier. If co-pay applies, you will need to pay that at the time of service. Please understand that your insurance policy and benefits are a contract between you and your Insurance carrier. You should direct any questions or complaints regarding coverage or payment directly to your insurance carrier.

It is your responsibility to identify the insurance plan that you are covered under and to know what laboratory or hospital facility you must use, whether or not a referral is needed or pre-authorization is required. Any charges incurred because of failure of improper identification of HMO/PPO membership or requirements will be the responsibility of the patient.

Any missed appointments without a 24 –hour cancellation notice or change will result in a $20 service charge to your account.

I HAVE READ AND UNDERSTAND THE ABOVE PAYMENT POLICY INFORMATION.

Signature **Date**

5164 Monroe Street, Suite 202 Toledo, Ohio 43623 Phone: (419) 898-2104
530 Washington Street, Port Clinton, Ohio 43452 Phone: (419) 732-2618 Fax: (419) 732-1998

Dr. Judge is a Fellow of the American College Foot & Ankle Surgeons and is board certified in rear foot and ankle surgery