WELCOME TO CT PODIATRY & FOOT SURGERY

We look forward to seeing you.

You may visit: www.AmericanPodiatry.com for our office information.

This instruction page is to assist with the ease of your registration on your first visit.

1. To make the best use of your important time, please arrive fifteen minutes PRIOR to your appointment time with the following registration forms completed.

2. We have designated appropriate time for your visit. But if you arrive late or without this registration or need to complete any other paperwork or registration/insurance process, you may be taking time away from your allotted visit. Therefore, we ask you to arrive with all necessary information.

3. To complete these forms you will need to print them and then handwrite on the form to complete it. When printing, please do not change size, fonts nor margins. There is a reason that this form is to fit into a specific scanned document. ((There should be exactly FOUR pages, each of which will say, at the top: CT PODIATRY & FOOT SURGERY, underneath which the page number of the total, will be stated. We must caution against changing margins or sizes as sometimes is done when printing from a phone because if it is printed and completed in a different format than that which you see on a computer screen, it will not scan into our system directly and you will be asked to complete the forms again, upon arrival - if you are unsure then your may fax the document to the office prior or simply make sure you arrive early enough prior to your appointment time to complete the registration papers.))

4. If there is any other party who is needed to assist you to complete the registration, or someone who is power of attorney needed or any possible special assistance required, either to complete these forms, or for your visit, please inform us prior so that we may make possible accommodations.

5. There is one medical consent form to sign upon arrival.

6. Please bring any and all insurance cards and associated information along with a photo ID, such as a driver's license.

7. If you have any previous and available records from any foot or ankle condition it is helpful to have this information forwarded to us, prior to your visit, or at least available at the time of your visit.

8. According to insurance regulations, Co-Payments are due at the time of the visit and please be aware if your insurance has any deductible amount not yet reached according to your own insurance plan. We do verify insurance eligibility and if your insurance informs us of any financial estimates different than what you may think is correct, you will need to abide by our insurance verification that day. If there is discrepancy, you may contact your insurance at a later time, not using up your own appointment time.

9. We try to allot appropriate time, for more lengthy visits and for 'New Patients'. We do have a long waiting list/cancellation list. So, missed or broken appointments hurt everyone. Missed appointments or appointments cancelled within a period of less than 24 hours prior to the appointment time may incur a fee to be paid prior to re-scheduling. We understand that last minute issues arise, but please call.

10. Pertinent to insurance plans or related questions, our doctor is a provider on the Surgical Staff of Hartford HealthCare, for hospital based surgery and hospital admissions and consults. Your appointment is in a Hartford HealthCare facility , however, your scheduled appointment is considered to be at a private office separate from Hartford HeathCare.

11. Most all major health insurance plans and Medicare as well as Medicare Advantage plans are accepted, as well as workman's compensation plans.

If you need to send any correspondence prior to your visit, please either mail or fax.
(The information can not be emailed.)

CT Podiatry & Foot Surgery,
330 Washington St. suite 310
Norwich CT 06360
860-886-4747
FAX # (860) 886-4848

CT Podiatry & Foot Surgery,
200 Merrow Road (in Hartford HealthCare Medical)
Tolland, CT 06084
860-872-Foot (3668)
FAX # (860) 886-4848

**Norwich is Mailing address **

CT PODIATRY & FOOT SURGERY

NAME: ____ I like to be called: _______________

DATE OF BIRTH _______/_________/____________ AGE _____________

GENDER: ____ FEMALE ____MALE ____UNSPECIFIED ____Rather not Answer

Status: ____Single _____Married _____Divorced _____Widowed

4

Social Security Number: __ __ __ - __ __ - __ __ __ __

____

STREET ADDRESS TOWN ZIP CODE

________________________ _______________________ ______________________

HOME PHONE NUMBER CELL PHONE NUMBER WORK PHONE NUMBER

Please circle the first contact number. We may send text reminders for appointments which may result in data rates

EMAIL: ________________________________@______________________

Is Guardian needed? ___No ___Yes (If yes, what is reason?) _____________________

OCCUPATION, EMPLOYER ____

Describing type of work can help medical planning

EVEN IF RETIRED, PREVIOUS Occupation _______________________________________

IF STUDENT, school and grade ____

WHO REFERRED YOU?

___Doctor ___Family ___Friend ___Phone Book ___Internet ___ Insurance

IF A DOCTOR referred you, please provide name of Doctor ____________________________

IS ANY OF YOUR FAMILY MEMBERS A PATIENT HERE? ___________________________

____

EMERGENCY CONTACT NAME RELATION ADDRESS

EMERGENCY CONTACT: Work phone ____________________________

Home phone ____________________________

Cell phone ____________________________

WHO IS THE **PRIMARY CARE PHYSICIAN**? __________________________________

YOUR **PHARMACY**: ____

NAME LOCATION

WHAT IS THE EXACT REASON FOR THIS APPOINTMENT? ______________________

If it is for 'Foot pain' please be specific.

Sometimes people have additional concerns to be addressed on future visits
Do you have any other concerns for which you are also seeking treatment?

______________________________ ______________________________

Circle any of the following medical conditions you have ever had.

Anemia	Arthritis	Asthma	Coronary Artery Disease
Stroke	Thyroid	Epilepsy	High Blood Pressure
HIV/AIDS	Stomach Ulcer	Esophagus Ulcer	Intestinal Ulcer
Cardiac Disease	Heart Murmur	Liver Disease	Irregular heartbeat
Kidney Disease	Rheumatic Fever	High Cholesterol	Bleeding Disorder
Respiratory Disease	Pacemaker	Defibrillator	Cardiac Bypass
Hepatitis	Phlebitis	Seizures	Chemical Dependency
Anxiety	Depression	Colitis	Artificial Joint
Polio	Lyme Disease	Digestive disorder	Low Back Problems
Sjogrens	EDS	Osteoporosis	
Neuropathy	Stents in leg	Difficulty Walking	Circulation Problems
Foot Cramps	Restless Leg	Swollen Feet	Swollen Ankles
Raynauds	Arch Pain	Heel pain	Leg or Foot Ulcer
Leg Cramps	Cellulitis	Gout	Foot Injury
Diabetes	Sciatica	Fibromyalgia	Cancer of _____________

Any Other Medical Condition not listed above ______________________________________

Circle if your family has: Vascular Disease Heart Disease Cancer Stroke Diabetes

LIST ALL MEDICATIONS AND DOSAGES, INCLUDE OVER THE COUNTER:

YOU MAY SUPPLY A LIST IF AVAILABLE CHECK HERE: ( )

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10 ______________________

Please list any and all previous surgeries and their approximate years when applicable:

_______________ ______________________________

_______________ _______________ _______________

ALLERGIES ______________________________________

Do you have Allergy to Latex? ___No ___Yes

Do you have Allergy to Tape? ___No ___Yes

Do you have Allergy to Sulfa medicines? ___No ___Yes

Do you have Allergy to Penicillin? ___No ___Yes

WHAT IS YOUR HEIGHT: ___________

WHAT IS YOUR WEIGHT? ___________

WHAT IS YOUR SHOE SIZE? __________

CIRCLE WHAT SHOE TYPE YOU MOSTLY WEAR? ATHLETIC DRESS WORKBOOTS SANDALS

Do you use alcoholic beverage more than occasional? ___No ___Yes
If Yes, amount: ____________________________
Do you currently or previously smoke(d) cigarettes? ___No ___Yes
If Yes, amount: ____________________________
Do you participate in any athletic activity? ___No ___Yes
If yes, describe: ___________________________
Do you wear or are you supposed to wear compression stockings? ___No ___Yes

Do you or are you supposed to pre-medicate prior to dental procedures? ___No ___Yes

Have you ever worn custom/prescription foot orthotics previously? ___No ___Yes

Have you ever taken chemotherapy medications? ___No ___Yes

Do you require assistance to walk up and down stairs? ___No ___Yes

Do you need someone to drive a vehicle for or with you? ___No ___Yes

Have you ever had a poor reaction to anesthesia? ___No ___Yes

Do you take extra time or medication to 'get numb', such as with dental procedures? ___No ___Yes

Has any family member ever had leg ulcers or amputation? ___No ___Yes

Have you been treated at a wound care center for a condition below the knee? ___No ___Yes

Have you ever had an electronic nerve test in the lower leg area? ___No ___Yes

Are you seeking an additional opinion from on a previous medical visit? ___No ___Yes

Have you **EVER** had any treatment for any foot or ankle condition? ___No ___Yes

If you have had previous foot/ankle condition treatment….

Previous Doctor treating ankle/foot condition: ______________ Approximate date ____________

If you have had Foot or ankle Xrays in the last five years, where were they taken?____ ____________

What was the reason for the xrays? ____

If you are seeking an additional medical opinion, it is in YOUR best interest to have the previous medical report sent to our office PRIOR to your visit so that the most optimal planning may be allotted for you.

CT PODIATRY & FOOT SURGERY

When you arrive at the office, we ask that you have your insurance card(s) available. To help expedite your registration process and verify your coverage, you may either include an image of the front and back of your card(s) or simply complete this page with specific attention to correctly entering all pertinent policy numbers.

(1) PRIMARY INSURANCE INFORMATION

______________________________ ________________________ ___________________
INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

If the policy is through a different person, please provide name and birthdate and relation to you:

____
POLICY HOLDER, IF NOT SELF BIRTHDATE RELATION TO YOU

(2) SECONDARY INSURANCE INFORMATION

IF THERE IS NO SECONDARY INSURANCE, CHECK HERE ( )

______________________________ ________________________ ___________________
INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

If the policy is through a different person, please provide name and birthdate and relation to you:

____
POLICY HOLDER, IF NOT SELF BIRTHDATE RELATION TO YOU

(3) IF YOU HAVE A MEDICARE PLAN…. IS IT?

_____COMBINATION MEDICARE ADVANTAGE PLAN
_____MEDICARE WITH A SEPARATE SECONDARY
_____MEDICARE WITHOUT A SEPARATE SECONDARY
_____I DON'T KNOW

(4) DO YOU HAVE ANY ADDITIONAL PAYMENT ASSISTANCE PLAN?

Name of Plan: ____