

PATIENT REGISTRATION

Date _____

Name _____ Telephone _____

Address _____
Street Apt # City State Zip

Sex: _____M _____F Age _____ Birth date _____ Patient SS# _____

_____ Single _____ Married _____ Widowed _____ Separated _____ Divorced

Occupation _____ Employer _____

Employer Address and Phone _____

Insurance _____

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Employer _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Phone _____ Relationship _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to J. Timothy Harlan, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

IF APPLICABLE, PLEASE COMPLETE:

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to J. Timothy Harlan, D.P.M., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

J. Timothy Harlan, D.P.M., M.S.
926 E. McDowell Road, Suite 211, Phoenix, AZ 85006
Phone (602) 251-3113 Fax (602) 251-3114

MEDICAL HISTORY

Name _____

Date _____

Reason for today's visit: _____

Please indicate if you have had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Allergies to Medicines or Drugs | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |

Cigarette/Tobacco use _____ Years smoked _____

Surgeries: _____

Hospitalization: _____

Family Physician: _____ Last visit date: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? yes no

If yes, please explain _____

Medications: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Allergies:

- | | |
|--|--|
| <input type="checkbox"/> Adhesive / Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | Other _____ |

Consent:

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.

Patient's Signature _____

Date _____