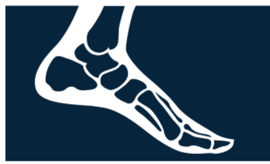


NEW MINOR PATIENT REGISTRATION FORM

Patient Information

Patient Last Name: _________________ Patient Legal First Name: _________________ Preferred Name: ____________ Middle Initial:_____

Patient Date of Birth: __ /___/_____ Patient Social Security #: ______________ Gender: M / F Marital Status: ❒Single ❒Married ❒Other

Parent/Guardian Full Legal Name: _______________________________ Relationship to Patient: ____________ Parent SSN: ____________

Primary Language: ❒English ❒Other __________________________ Ethnicity : ❒Not Specified ❒Hispanic/Latino ❒Not Hispanic/Latino

Race: ❒Not specified ❒American Indian ❒Asian ❒Alaska Native ❒Black/African American ❒Native Hawaiian ❒White

Home Phone: (____)_______-__________ Cell Phone: (____)_______-__________ Email for Patient Portal: __________________________

I understand that the above information will be used to contact me regarding appointments, treatments and billing matters. I agree to phone, text, and email communications from this office, with the understanding that I can opt out of text (msg & data rates may apply) and emails if I so choose.

Street Address (No PO Box): _________________________________ City: ___________________ State: _________ Zip Code: __________

Pharmacy: ____________________________ City: _____________________ Crossroads/Zip Code: ________________________________

Primary Care Doctor: ______________________ City: ____________ Date Last Seen: ____________ Office Phone #: (___)____-__________

Emergency Contact Name: ____________________________ Relationship: ___________________ Best Phone #: (____)______-_________

Primary Insurance Carrier: ___________________________ Name of Policy Holder: ____________________ Policy Holder DOB: _________

Secondary Insurance Carrier: ___________________________Name of Policy Holder: ___________________ Policy Holder DOB: ________

Auto or Work Comp? YES / NO If yes, Date: ___________ Claim #: ____________ Claim Rep Name/Phone #:_________________________

Medicare Only:Are you enrolled in Hospice? YES / NO Do you receive home health care? YES / NO Do you live in a nursing home? YES / NO

HOW DID YOU HEAR ABOUT OUR PRACTICE? ❒Family/Friend: ____________________________________ ❒Google

❒Facebook ❒Instagram ❒Event ❒Insurance Website ❒Signage ❒Dr:_______________________ ❒Other: ________________________

Privacy Information

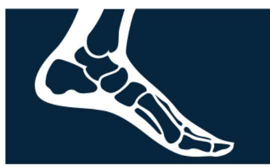
Where may we contact/leave you message(s): **HOME:** ❒ Yes ❒ No **CELL:** ❒ Yes ❒No

Name of person(s) who can have access to your records/PHI or pick items up for you:

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Name: ____ Relationship: ____



Current Medical History

Patient Last Name: ______________________ Patient Legal First Name: ______________________

Patient Shoe Size: ________ Weight: ______ Height: _______ Do you exercise regularly? ❐Yes ❐No If yes, how often? ____

Are you Diabetic? YES / NO If yes, Diabetic Care Dr:______ Date Last Seen: ______ Last A1C: ____Year Diagnosed: ____

Allergies: ❐None ❐Adhesive/Tape ❐Anesthetics ❐Aspirin ❐Blood Thinners ❐Codeine ❐Dairy ❐Demerol ❐Eggs ❐Erythromycin ❐IV contrast ❐Iodine ❐Latex ❐Penicillin ❐Seafood ❐Sulfa ❐Other(s): ______________________

List all Hospitalizations (Reason and Date): ______________________

List all Surgeries (Type and Date): ______________________

Current Medications

Medication List can be copied and attached separately if available - You do NOT have to rewrite medications!

❐None

Medication 1: ____________ Dosage: _____ Medication 2: ____________ Dosage: _____
Medication 3: ____________ Dosage: _____ Medication 4: ____________ Dosage: _____
Medication 5: ____________ Dosage: _____ Medication 6: ____________ Dosage: _____
Medication 7: ____________ Dosage: _____ Medication 8: ____________ Dosage: _____

Review of Systems

Check all of the following problems below that apply to you on a regular basis

Constitutional: ❐Chills ❐Fatigue ❐Fever ❐Weakness

Head: ❐Dizziness ❐Fainting ❐Headaches

Neurological: ❐Numbness ❐Strokes ❐Tingling ❐Tremors

Skin: ❐Dryness ❐Eczema ❐Lumps ❐Mole Changes

Endocrine: ❐Thyroid Issues ❐Weight Loss ❐Weight Gain

Psychiatric: ❐Depression ❐Anxiety ❐Insomnia

Gastrointestinal: ❐Constipation ❐Diarrhea ❐Heartburn ❐Hepatitis ❐Liver Disease ❐Nausea

Hematologic/Lymph: ❐Anemia ❐Blood Clots ❐Chemotherapy ❐Slow Healing Cuts ❐Swollen Glands ❐Transfusion Reaction

Musculoskeletal: ❐Arthritis ❐Back Problems ❐Joint Implants ❐Joint Pain/Stiffness ❐Muscle Cramps/Stiffness ❐Paralysis ❐Restricted Motion

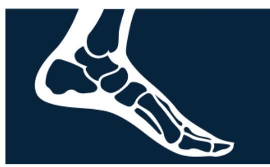
Cardiovascular: ❐Chest Pain ❐Cramps ❐Cool Extremities ❐Hair loss on legs ❐High Blood Pressure ❐Heart Attack ❐Palpitations ❐Leg/Foot Ulcers ❐Shortness of Breath ❐Varicose Veins ❐Vascular Grafts ❐Vascular Stents

Past Medical History

Mark "None" if the history below does NOT apply to you

❐None
❐AIDS/HIV
❐Abnormal Heart Beat
❐Anxiety
❐Asthma
❐Bleeding Disorder
❐Blood Clot
❐CAD
❐Cancer (Type) _____
❐Chronic Back Pain
❐Chemotherapy
❐Circulation Problems
❐Dementia
❐Depression
❐Gastric Reflux
❐Glaucoma
❐Gout
❐Heart Attack
❐Hepatitis (Type) ___
❐High Cholesterol
❐High Blood Pressure
❐Kidney Disease
❐Liver Disease
❐Multiple Sclerosis
❐Neuropathy
❐Osteoarthritis
❐Parkinson's Disease
❐Rheumatoid Arthritis/Autoimmune
❐Seizures
❐Stroke
❐Thyroid Disorder
❐Ulcers/Sores
❐Other: ____________

Are you currently pregnant or nursing? YES / NO



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Social History

Employment Status: ❐Full-Time ❐Part-Time ❐Retired ❐Unemployed ❐Student   Occupation: ________________ Employer: ____________

Smoking History: ❐Non-Smoker ❐Current Smoker - Amount/day: ________________ ❐Former Smoker - Years of cessation: _________
❐Marijuana - Amount/day: _____________

Do you drink alcohol? YES / NO   If yes, ❐socially ❐occasionally ❐heavily   Other Drug Use?: ___________________________________

Family History

Place an "X" on all applicable lines	**Father**	**Mother**	**Both**
Diabetes	_____	_____	_____
Cardiovascular Disease: ___________________	_____	_____	_____
Cancer: _________________	_____	_____	_____
Bleeding Disorders	_____	_____	_____
Bunion	_____	_____	_____
Hammertoe	_____	_____	_____
Flat Feet	_____	_____	_____
High Arch Feet	_____	_____	_____
Other: ________________________	_____	_____	_____

Current Foot and Ankle Conditions

Check all of the following problems below that apply to you

Musculoskeletal:

❐Ankle Sprain ❐Arch Pain ❐Broken Foot/Ankle ❐Bunion(s) ❐Childhood Foot Problems ❐Flat Feet
❐Gait (Walking) Problem ❐Gout ❐Hammertoe(s) ❐Heel Pain ❐High Arch Feet ❐In-Toeing
❐Neuroma ❐Orthotic Use ❐Shoe Insert Use ❐Toe Walking

Vascular:

❐Lower Extremity Stent(s) ❐Raynaud's Disease ❐Varicose Veins

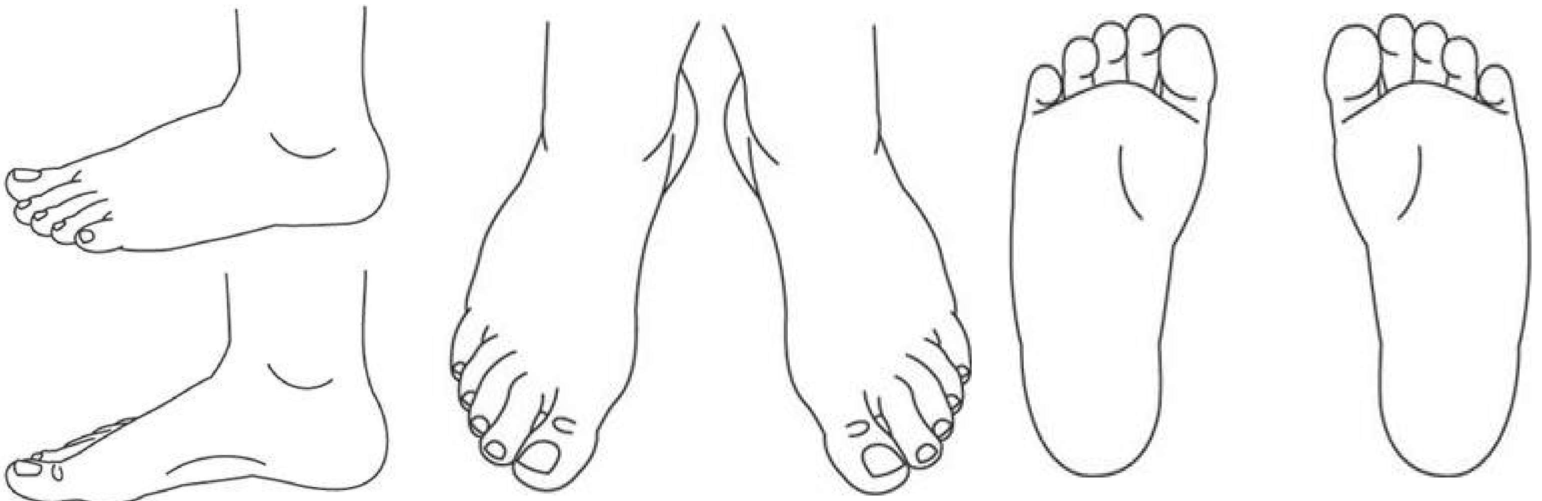
Skin:

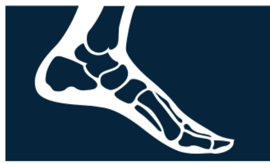
❐Athlete's Foot ❐Fungal Nails ❐Ingrown Nails ❐Keloid Scar ❐Wart(s) ❐Ulcer(s)

Neurological:

❐Charcot Neuropathy ❐ Burning ❐Unsteady Gait

Please indicate the affected area on the diagram below:





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RESPONSIBLE PARTY

The primary individual who accompanies a child (18 or under) to Brighton Foot and Ankle is responsible for all fees, regardless of guardianship or custody arrangements. All patients 18 or under must be accompanied by an adult, Responsible Party, at every appointment. This form must also be completed if the patient has a medical Power of Attorney. If the patient arrives unaccompanied to any appointment the patient will not be seen and the appointment will be rescheduled to a time when the patient can be accompanied by a responsible adult.

Patient Last Name: ___________________________ Patient Legal First Name: _________________________ DOB: ______________________

Responsible Party Name: __________________________ Relationship to Patient: ________________ Responsible Party DOB: ____________

Responsible Party Address (NOT PO Box): ______________________________________ City: ______________ State: _______ Zip: ________

As the responsible party, if you are unable to bring the patient to their appointment you can approve up to (3) alternate adults that you consent to bring the patient to their appointments and make medical decisions for the patient in your absence. We will not be able to see the patient if they are not accompanied by a parent or an approved adult listed below. **Please note that all approved parties must be prepared to pay co-payment and/or outstanding balances when applicable.**

Approved Alternate Adult(s) that may bring the patient to appointments and make medical decisions on your behalf:

Last Name: ___________________ First Name: ____________________ DOB: ________________ Relationship to Patient: ____________

Last Name: ___________________ First Name: ____________________ DOB: ________________ Relationship to Patient: ____________

Last Name: ___________________ First Name: ____________________ DOB: ________________ Relationship to Patient: ____________

INSURANCE PATIENTS ONLY

Please initial ***ONE*** and sign below

_________ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility- even if I have secondary insurance.

_________ I understand that my insurance is Out-of-Network and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

__________ I understand that even though I have insurance I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance will NOT be billed and fees for service rendered must be paid today.

____ ____________________________________

Signature **Date**

NO INSURANCE/CASH PATIENTS ONLY

Please initial and sign below if you have no insurance

_______ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered.

____ ____________________________________

Signature **Date**

ATTEST

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Brighton Foot and Ankle immediately of any changes to the above information and annually upon the office's request. I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy Version 1.22, Authorization from Patient or Legal Representative version 1.22, and Notification of Office Policies and Procedures version 1.22 (available in our waiting room and/or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "Notifications of Office Policies and Procedures", "HIPAA Policy Notice of Privacy Practices" and "Authorization from Patient or Legal Representative."

____ __________________________________ ______________________ __________

Print Patient's Name or Legal Representative **Signature** **Relationship to Patient** **Date**