ACTIVE PODIATRY
YONG S. CHAE, DPM

PATIENT REGISTRATION

PLEASE PRINT **Date__________________**

PATIENT NAME:____
LAST FIRST MI
ADDRESS:____
CITY:______________________________**STATE:**_____**ZIP:**_______________
HOME PHONE: (_____)__________________**ALTERNATE PHONE:(_____)**_________________
SEX:______**DATE OF BIRTH:**_______________**SSN:**______________________________**MARITAL STATUS**___________
PATIENT'S EMPLOYER:____________________________**EMPLOYER ADDRESS:**_____________________________
CITY:______________________________ **STATE:**______**ZIP:**______________
EMPLOYER PHONE NUMBER:_________________________ **EXT:**____________

RESPONSIBLE PARTY NAME:____**RELATIONSHIP**__________________
LAST FIRST MI
ADDRESS:____
CITY:______________________________**STATE:**_____**ZIP:**____
HOME PHONE: (_____)__________________**ALTERNATE PHONE:(_____)**_________________
SEX:______**DATE OF BIRTH:**_______________**SSN:**_______________**MARITAL STATUS**___________
RESP. PARTY EMPLOYER:___________________________**EMPLOYER ADDRESS:**_____________________________
CITY:______________________________ **STATE:**______**ZIP:**______________
EMPLOYER PHONE NUMBER:_________________________ **EXT:**____________

INSURANCE SUBSCRIBER NAME: _____________________________**DOB:** _________ **SSN:** ______________________
ADDRESS: ____
EMPLOYER: ____

PRIMARY INSURANCE COMPANY: ____
SECONDARY INSURANCE COMPANY: ____
*****COPY OF INSURANCE CARD/CARDS REQUIRED*****

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:____

PHONE:____

HOW DID YOU HEAR ABOUT US? (circle one) Yellow Pages Newspaper Ad Radio Hospital Internet
Friend/Relative ____**(name)**
Physician referral (name & address)____
____

Active Podiatry
Financial Policies

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we **require** you to read and sign. This will remain in effect for all services rendered during your time as a patient at Active Podiatry.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD

Office Policy on Payment
It is our policy to require payment of all office charges at the time they are given. In the event that any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including a reasonable attorneys fee. If your check is returned, you will be assessed a **$30.00 fee** and all future payments will be expected in cash, money order or credit card.

Insurance Policy
We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **If you do not inquire with us as to whether we accept your insurance, it will be your responsibility to contact your insurance company. If we do not accept your insurance and you wish to receive care from us, you will be responsible for all charges up front. You are responsible for all deductibles, co pays and charges not covered by insurance. If you do not have your insurance card at the time of your visit, you will be given the option to reschedule otherwise you will be required to pay *all* charges up front.** Please understand that we cannot, as a third party become involved in prolonged insurance negotiations, this is your responsibility. You may be asked to sign and date a procedure specific waiver if we believe that your insurance may deny payment for that service.

Worker's Compensation
Worker's compensation will be filed if the patient notifies Active Podiatry upon scheduling appointment and supplies billing information upon check in. Details of the accident will be required and a worker's compensation for will be completed.

Self Pay
Payment is expected at the time of visit before examination is initiated. If any procedures, injections, or X-Rays are necessary, payment in full will be collected before they are performed. There are no exceptions.

Missed Appointments
We reserve the right to charge for missed appointments. Please help us to serve you better by keeping scheduled appointments.

I authorize the release of medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the above and accept financial responsibility in full for this account.

Signed:___________________________________ **Date:**___________________________
Patient, Parent or Guardian

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME:____

PHONE NUMBER:_________________________ **RELATIONSHIP:**___________________________

ADDRESS:____

Health History

Patient Name________________________________ Birth Date______________ Age__________
Height _______________ Weight__________________ Shoe Size________________________
Family Physician ___________________________________ Date Last Seen___________________
Pharmacy _________________________________ Pharmacy Phone _________________________
Pharmacy address____

Podiatric History
Have you seen a podiatrist before? YES ☐ NO ☐
If you answered **yes**, please complete the following information:
Doctor's Name __________________________ Date of Last Visit______________________
Condition for which you were treated ____
Describe the condition that brings you to our office today:
____
____
____
Occupation____
Athletic activities in which you participate (Please list the activities and how often you participate):

Activity	Frequency

Medical History
Please mark which conditions you have or have had in the past:

AIDS/HIV	☐	Stomach ulcers	☐	Emphysema	☐
Anemia	☐	Thyroid disorders	☐	Psychiatric disorders	☐
Arthritis	☐	Varicose veins	☐	Neuropathy	☐
Artificial heart valve	☐	High cholesterol	☐	Gout	☐
Bleeding disorder	☐	Hepatitis	☐	Heart attack	☐
Blood clots in legs/lungs	☐	High blood pressure	☐	Heart murmur	☐
Mitral valve prolapse	☐	Irregular heart beat	☐	Cancer	☐
Diabetes	☐	Kidney disease	☐	Other________________	☐
Seizure	☐	Stroke	☐		
Gallstones	☐	Asthma	☐		

Please list surgeries you have had:	Date of Surgery:

Is there a possibility that you could be pregnant? ☐YES ☐NO
If yes, how many weeks gestation? ______________

Family History

Please mark which conditions your father, mother, siblings, or children have had and indicate the relationship in the space provided.

Heart problems	☐___________________	High blood pressure	☐___________________
Asthma/emphysema	☐___________________	Stroke	☐___________________
Diabetes	☐___________________	High cholesterol	☐___________________
Cancer	☐___________________	Other	☐___________________

If you marked **other** please explain:____

Social History

Alcohol	☐YES	☐NO	How much per week?________________
Smoke	☐YES	☐NO	Packs per day?______________________
Former Smoker	☐YES	☐ NO	How long ago?______________________

Are you now, or have you been under the care of a doctor other than you primary care doctor over the last two years? ☐YES ☐NO

If you answered **yes**, please explain:____

Medications

List all medications you are currently taking including over-the-counter medications and vitamins:

____

____

____

____

____

Allergies

Mark which items you have an allergy to and the reaction you had in the space provided.

NO KNOWN ALLERGIES ☐

☐ Adhesive tape______________	☐ Sulfa drugs________________	☐ Penicillin___________________
☐ Aspirin_____________________	☐ Latex______________________	☐ Iodine_____________________
☐ Codeine___________________	☐ Local anesthetic_____________	

_

List any other allergies and reactions: ____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric condition(s).

____ _____________________________

Signature of patient or guardian Date

ACTIVE PODIATRY
YONG S. CHAE, DPM

E-PRESCRIBING CONSENT FORM

By signing this consent form, you are agreeing that Yong S. Chae, DPM can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

______________________________	______________________________
Print Patient Name	Patient's Date of Birth
______________________________	______________________________
Signature of Patient or Guardian	Relationship to Patient