PATIENT REGISTRATION FORM FOR AMANDA M. MATZ, DPM, A PODIATRY CORPORATION

GENERAL INFORMATION

Patient Legal Name_____ **Birthdate**_____ **Age**_____ **F**_____**M**_____

Address_____ **City**_____ **State**_____ **Zip**_____
Home Phone_____ **Cell Phone**_____

Marital Status_____
Emergency contact_____ **Relationship to patient** _____
Phone Number_____

Parent/Guardian (if minor or conservator)_____
Address_____ **City**_____ **State**_____ **Zip**_____

MEDICAL INSURANCE INFORMATION

Person responsible for payment_____
Primary Insurance_____ **Secondary Insurance** _____

PRIVACY POLICY INFORMATION and PREFERENCES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
I authorize Dr. Amanda Matz to discuss all my medical information with the following people:

1. _____ 2._____ 3._____
This information will be made available to my insurance companies and any other practitioners involved in my treatment.

Can we leave messages regarding your medical information and test results on your home and cell phone?
Yes ____ No ____

HIPPA: NOTICE OF PRIVACY POLICY
Your name and signature on this form indicates that you have received a copy of our Notice of Privacy Practices for Protected Health Information on the date listed below from Amanda Matz, DPM, A Podiatry Corporation.

These authorizations are effective now and will remain in effect until I revoke them in writing.
I understand that I have the right to receive a copy of this authorization.

Signature: _____ **Date:** _____
If not signed by the patient, please indicate the relationship:

( ) Parent or guardian of minor patient.
( ) Guardian or conservator of an incompetent patient.

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of patient's receipt of our Notice of Privacy Policy, but acknowledgement could not be obtained from the patient for the following reason:
_____
Staff Signature: _____ Date: _____

MEDICAL INFORMATION FORM FOR AMANDA M. MATZ, DPM, A PODIATRY CORPORATION

Name:_____ Age:_____ Date of Birth:_____
How would you like to be addressed: _____

Describe your foot problem (R/L):_____
How long have you had this problem:_____
Pain Level (1-10):_____ Previous foot/ankle problems:_____
Height:_____ Weight:_____ Shoe Size:_____
Family Doctor:_____ Date of last visit:_____ Referred by:_____
Have you ever been treated by a podiatrist before?_____ By Dr.?_____
Allergies:_____
Medications:_____
_____
_____
Pharmacy name and address:_____
Are you pregnant or nursing?_____

PAST SURGERIES:_____

FAMILY HISTORY (INDICATE FAMILY MEMBER)

- Arthritis:_____
- Cancer:_____
- Heart Disease:_____
- Bleeding Disorder: _____
- Diabetes:_____
- Neurological Disorder: _____
- Flat Feet:_____
- Bunions:_____
- Hammertoes:_____
- Other Medical Diseases :_____

SOCIAL HISTORY

Did you ever smoke ?_____ # of packs per day?_____ Year started ?_____Year quit?_____ Smokeless products?_____
Do you drink?_____ # of drinks per week?_____ Wine/Beer/Liquor (circle)
Do you have a history of alcohol use/abuse?_____
Do you have a history of drug use/abuse?_____

Occupation:_____ Employed by:_____
Signature:_____ Date:_____