WILMINGTON
WOUND CARE
&PODIATRY
CENTER

REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____/_____/_____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____/_____/_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (*or my dependent*) have insurance coverage with _____ and assign directly to **Dr. Richard R. Recko, DPM**, 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Richard R. Recko, DPM** 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 HCFA-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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Relationship Date

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Cell _____

Email _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?

☐ Yes ☐ No If yes, please list below:

Name _____

Last Visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

If Yes, which family member/members?

_____

_____

Your occupation

_____

Athletic activities in which you participate *(please list and indicate frequency)*

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Bunions	☐Yes	☐No
Corns and Calluses	☐Yes	☐No
Cramps or Numbness in Feet or Legs	☐Yes	☐No
Flat Feet	☐Yes	☐No
Foot or Leg Cramps	☐Yes	☐No
Heel Pain	☐Yes	☐No
Ingrown Toenails	☐Yes	☐No
Plantar Warts	☐Yes	☐No
Swelling in Ankles/Feet	☐Yes	☐No
Tired Feet	☐Yes	☐No

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
		Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves or Artificial Joints	☐Yes ☐No	Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
		Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chest Pain	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

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 _____

_____

_____

6. ALLERGIES *check all that apply*

Food:	**Drug:**	**Environmental:**	**Other Allergies:**
☐ Gluten	☐ Anticoagulant Therapy	☐ Adhesive/Tape	☐ _____
☐ Milk/Dairy	☐ Aspirin	☐ Cats	☐ _____
☐ Peanut	☐ Codeine	☐ Dogs	☐ _____
☐ Seafood	☐ Demerol	☐ Pollen	☐ _____
☐ Soy	☐ Iodine	☐ Mold	☐ _____
☐ Tree Nuts	☐ Local Anesthetics	☐ Perfume	☐ _____
☐ Eggs	☐ Novacaine	☐ Latex	☐ _____
☐ Sulfites	☐ Penicillin	☐ Nickle	
☐ Wheat	☐ Sulfa Drugs	☐ Dust	

7. LIFESTYLE

Tobacco Use:

☐ Never

☐ Previously; quit _____ yrs. ago

☐ Current; _____ packs per day

Alcohol Use:

☐ Never ☐ Daily

☐ Rarely

☐ Moderate

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 _____

8. MEDICATION SHEET

Please list your medications, both prescription ***and*** over the counter and Dosage, Doctor and Date you started taking it.

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

Medication Name	Dosage	Prescribing Physician	Date Started	Date Stopped	Currently Taking?

9. PAD Assessment (Peripheral Artery Disease)

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque. Fill out the questionnaire so Dr. Recko can evaluate whether you may be at risk or have symptoms of PAD.

Circle Yes or No on the following questions and check all boxes that apply:

1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? **YES NO**

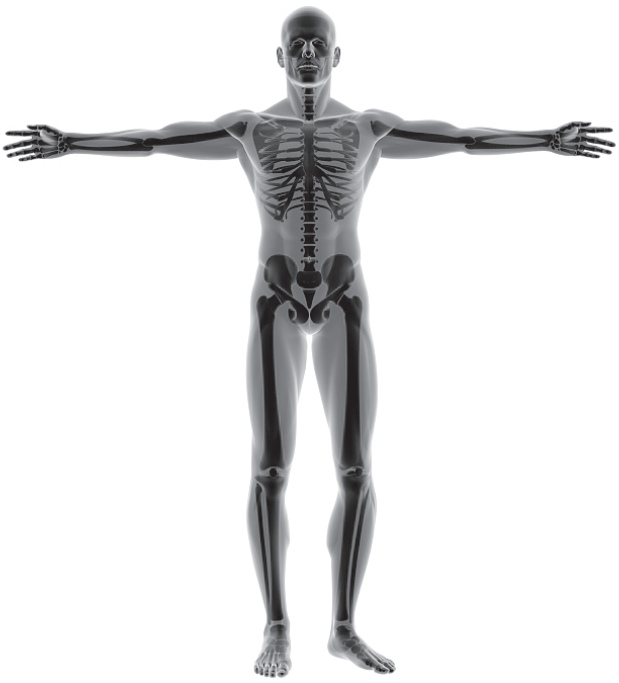
2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? **YES NO**
If yes, dates:_____

3 When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks? **YES NO**

4 If you answered Yes to #3, when do you feel the pain:

- ☐ After walking 1 block
- ☐ Climbing a flight of stairs
- ☐ After walking 100 yards
- ☐ Walking at increased speed

5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.



6 If you have pain, does the pain subside with rest? **YES NO**

7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? **YES NO**

8 Do you have any painful sores or ulcers on legs or feet that do not heal? **YES NO**

9 Are your legs discolored or bluish? **YES NO**

10 Check all that apply:

- ☐ I am a current smoker
- ☐ I have a history of smoking
- ☐ I have diabetes
- ☐ I have a family history of diabetes
- ☐ I have high cholesterol
- ☐ I have a family history of high cholesterol
- ☐ I have high blood pressure/hypertension
- ☐ I have a family history of high blood pressure/ hypertension
- ☐ I have/had coronary artery disease (CAD)/heart attack
- ☐ I have a family history of coronary artery disease (CAD) /heart attack
- ☐ I have had a stroke/mini-stroke/TIA
- ☐ I have a family history of stroke/mini-stroke/TIA

10. OFFICE POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive imply some financial responsibility on your part.

INSURANCE: We file insurance claims as a courtesy to our patients. We file primary and secondary insurance carriers only. Each individual therapist/physician has contracts with various insurance companies. Please check and see if your company is covered by your provider. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you have.

COPAYMENTS/DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

PRE-APPROVALS: You, the patient or the insured is responsible for the initial call to your insurance company if pre-approval is required. This is the policy of the insurance company. We are responsible for any additional sessions that may be needed for your continued treatment.

CANCELLATIONS: We require 24 hour notice on all cancellations so we may have the opportunity to schedule another patient that may need an appointment. **There is a charge** for any missed appointments or cancellations with less than 24 hours notice.

PAYMENTS: We accept the following payment methods: Cash, Check, and VISA/MasterCard. Please let the office know if you have any difficulties in resolving you bill.

RETURN CHECK FEE: An additional $30.00 will be added to your statement if the check is returned for insufficient funds.

If you should have any questions regarding our policies, just let us know.

_____ _____
Patient Signature Date

_____ _____
Witness Date

ACKNOWLEDGEMENT FORM: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate ____/____/____

_____ _____
Patient Signature Date

USE AND/OR DISCLOSURE AUTHORIZED: Please list the people/organizations that you are authorizing to use and/or disclose the protected health information. Please describe in detail the protected health information you are authorizing each person/organization to use and/or disclose.
Use other side if you need more room.

_____

_____

_____