LASER PODIATRY ASSOCIATES, LLC
Jennifer Mullendore, DPM, FACFAS
Kenneth Benjamin, DPM, FACFAS

Patient Registration
(PLEASE PRINT CLEARLY)

Patient's Name:_____ **SS #:**_____
First Name **MI** **Last Name**

Date of Birth:_____ **Age:**_____ **__Male__ Female** **__Single __Married __Widowed __ Divorced**

Street address:_____

City/State/Zip Code:_____ **Home phone with area code:**_____

Cell phone with area code:_____ **Email:** _____

Pharmacy name and phone with area code:_____

Patient's employer:_____**Occupation:**_____**Work phone with area code:**_____

Responsible party:_____ **Relationship: __Self __Spouse __Parent __Other:**_____

Responsible party's address:_____

In case of emergency, name of person to contact:_____

Phone number with area code:_____ **Relationship to patient:**_____

Is this work-related? __Yes __No If yes, date of injury?_____**Claim #:**_____

Primary Care Physician's name & phone number:_____

How did you hear about our office? _____

If patient is under the age of 18, a legal parent or guardian MUST accompany them for ALL visits. In the event that a parent or guardian is not able to attend the visit, a signed letter from the parent or guardian clearly stating the person authorized to consent to treatment must be brought for each visit.

Authorization to Disclose Health Information

By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history.

Name:_____ Relationship:_____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

Name:_____ Relationship:_____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ Phone Number:_____

Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____Group #:_____ Relationship To Insured:_____

Insurance Company # 2:_____ Phone Number:_____

Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____Group #:_____ Relationship:_____

- I hereby authorize the payment of medical benefits to **Laser Podiatry Associates, LLC** for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce collection of any amounts outstanding.
- I hereby authorize **Laser Podiatry Associates, LLC** to release any medical information necessary to complete and process my insurance claims.
- I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Laser Podiatry Associates, LLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.
- I authorize Laser Podiatry Associates, LLC, Jennifer E Mullendore DPM and/or Kenneth Benjamin DPM to treat me and use my personal health information for healthcare operations.

_____ _____
Patient OR Insured Signature (legal guardian signature if patient is a minor) Date

MEDICAL HISTORY

Reason for Visit:

_____

_____

_____

Shoe Size: _____ Height: _____ Weight: _____ Do you smoke? □Yes □No Packs/day:_____

Past tobacco use? □Yes □No Do you drink alcohol? □Yes □No

Female patients: Are you pregnant? □Yes □No Nursing? □Yes □No

Have you had previous foot or ankle surgery? □Yes □No

Have you ever worn custom made arch supports (orthotics)? □Yes □No

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? □Yes □No

Do you experience any pain at rest in your lower leg(s) or feet? □Yes □No

Do you experience foot or toe pain that often disturbs your sleep? □Yes □No

Are your toes or feet pale, discolored, or bluish? □Yes □No

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? □Yes □No

Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? □Yes □No

Have you suffered a severe injury to the leg(s) or feet? □Yes □No

Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? □Yes □No

Allergies: (please check those that apply or provide a list to copy)

□Penicillin	□Iodine	□Aspirin	□Adhesive Tape	□Sulfa
□Codeine	□Seafood/Shellfish	□Local Anesthetics	□Latex	□Other_____

Current Medications: Prescription and Non-prescription (Or provide a list to copy)

_____

_____

Prior surgery:

_____

_____

Illnesses: (Please check all that apply)

□Anemia	□Bleeding Disorders	□Hepatitis	□Lung Problems	□Stroke	□Other
□Arthiritis	□Diabetes	□High Blood Pressure	□Neck Pain	□Cancer	
□Asthma	□Gout	□Kidney Problems	□Numbness in Feet	□HIV/Aids	
□Back Pain	□Heart Disease	□Liver Disease	□Poor Circulation	□Blood clots	

Family History: (Please check all that apply)

□Anemia	□Bleeding Disorders	□Hepatitis	□Lung Problems	□Stroke	□Other
□Arthiritis	□Diabetes	□High Blood Pressure	□Neck Pain	□Cancer	
□Asthma	□Gout	□Kidney Problems	□Numbness in Feet	□HIV/Aids	
□Back Pain	□Heart Disease	□Liver Disease	□Poor Circulation	□Blood clots	

I hereby give my permission to the doctor(s) at Laser Podiatry Associates to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ DATE: _____