PALMETTO PODIATRY GROUP
of Anderson

NEW PATIENT REGISTRATION

Patient Name: _____ **MRN**: _____

Date of Birth: ____/____/_____ **Birth Sex**: M F **Social Security No.**: _____-____-_____

Mailing Address: _____

Home Phone: (_____) _____-_____ **Mobile Phone**: (_____) _____-_____

Email: _____

Advanced Directives: None Living Will DNR POA Surrogate (Please provide POA or surrogate paperwork)

IF APPLICABLE: **Facility Name**: _____

POA or Surrogate Name: _____ **Phone**: (_____) _____-_____

Required by government mandate (you may refuse):

Language: _____ **Race**: _____

Ethnicity: _____ **Marital Status**: _____

EMERGENCY CONTACT

Name: _____

Date of Birth: ____/____/_____

Phone: (_____) _____-_____

Relationship: _____

GUARANTOR INFORMATION (where financial statements are sent)

Name: _____

Billing Address: _____

_____

Phone: (_____) _____-_____

Relationship: _____

PRIMARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____

Date of Birth: ____/____/_____

Employer: _____

Relationship to policy holder: _____

SECONDARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____

Date of Birth: ____/____/_____

Employer: _____

Relationship to policy holder: _____

To the best of my knowledge, the above information is complete and accurate.

Patient or POA Signature: _____ **Date**: _____

Name: _____ DOB: _____ MRN: _____

****Please circle each section below ****

Would you like access to the online patient portal?	Yes	No
Can we send mail to the address on file?	Yes	No
Can we call the phone number on file?	Yes	No
Can we leave a voicemail on the machine?	Yes	No

Communication Preference (circle all that apply):

Appointments	Phone	Email	Text	
Billing	Phone	Email	Text	Mail
Newsletters	Phone	Email	Text	Mail

Who can we leave message with and speak to about your account and medical treatment?

Name: _____

Relationship: _____

- I acknowledge that the binder at the front desk provides access to the HIPAA/Privacy Policy for Palmetto Podiatry Group of Anderson, PA for me to review at my leisure. Copies upon request.
- I acknowledge that the binder at the front desk provides access to the Financial Policy for Palmetto Podiatry Group of Anderson, PA for me to review at my leisure. This includes providing permission for my insurance benefits to be paid directly to the healthcare provider, and for release of any medical information required to process my claim. Copies upon request. Financial Policy is also found on the website.
- I give consent to the Physicians and/or the staff of Palmetto Podiatry Group of Anderson, PA to perform office procedures and/or tests required for the diagnosis and/or treatment of my condition.
- I authorize Palmetto Podiatry Group of Anderson, PA to share and receive medical records from other providers and to obtain/have access to my medical history including my medication list.

By signing below, I acknowledge that I have read all the above information and have been given the opportunity to have my questions answered prior to signing.

Patient or POA Signature: _____ **Date**: _____

Name: _____ **DOB:** _____ **MRN:** _____

Reason for visit: Nails? Calluses/Corns? Other? _____

How long? _____ **Pain** ___/10 **Describe the pain:** _____

Previous Tx: _____

Primary Care Physician: _____ **PCP Last Visit**: _____

Pharmacy: _____

Recent Falls? Y N If Yes, When _____ **Injury? Y N**

Blood Pressure: _____ / _____ **Height**: _____ **Weight**: _____ **Shoe Size** R: _____ L: ____

Fasting Blood Sugar: _____ **HbA1c**: _____

When did you last get the following vaccinations?

Flu Vax: _____ **Pneumonia Vax:** _____ **COVID Vax:** _____

Social History (circle as it applies)**:**

Smoking Tobacco Status: Never Former Current **Packs Per Week** _____ **#Years Using** _____

Smokeless Tobacco Status: Never Former Current ***E-Cig/Vape Status***: Never Former Current

Alcohol Intake: Never Former Occasionally Daily ***Illicit Drugs***: _____

Exercise Level: Never Occasionally Weekly Daily ***Occupation***: _____

Relationship Status: Single Married Widowed Divorced Separated Other

Medications: None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: None _____

Name: _____ **DOB:** _____ **MRN:** _____

Medical History: (circle all that apply)

Alcoholism	COPD	Gout	Lymphedema	Skin Disorders
AIDS/HIV	Cancer	Headaches	Mental Illness	Sleep Apnea
Acid Reflux/GERD	Cataracts	Heart Disease	Mental Retardation	Stomach Ulcerations
Allergies	Chillblains	Heart Murmur	Neuropathy	Stroke
Alzheimer's	Coronary Artery Disease	Hepatitis	Organ Transplant	Substance Abuse
Anemia	Deep Vein Thrombosis	Hernia	Osteoporosis	Thyroid Problems
Anxiety	Dementia	Hyperlipidemia	Pacemaker	Urinary Retention
Arthritis	Depression	Hypertension	Parkinson's	Varicose Veins
Artificial Joints	Diabetes	Hypotension	Peripheral Vascular Dis.	_____
Asthma	Dialysis	Insomnia	Pregnancy / Nursing	_____
Atrial Fibrillation	Dyslipidemia	Irregular Heart Beat	Prostate Issues	_____
Bipolar	Edema	Kidney Disease	Pulmonary Embolism	_____
Bleeding Disorder	Fibromyalgia	Leg/Foot Ulcers	Raynaud's	_____
Blood Clot	Foot Deformity	Liver Disease	Rheumatoid Arthritis	_____
Breathing Issues	GI or Stomach Issues	Lung Disease	Schizophrenia	_____
Congestive Heart Failure	Glaucoma	Lupus	Seizures/Epilepsy	_____

Surgical History: _____

_____

_____

_____

Family History: (which immediate family member has these)

Alzheimer's: _____ Diabetes: _____

Arthritis: _____ Heart Disease: _____

Coronary Artery Dis.: _____ Hypertension: _____

Cancer: _____ Kidney Disease: _____

Dementia: _____ Strokes: _____

Depression: _____ Thyroid Disorder: _____

Other: _____