

TODAYS DATE \_\_\_\_\_

**Dr. Donald Harrison DPM**  
**Foot and Ankle Institute of Maryland**

**PATIENT REGISTRATION FORM**

<b>LAST NAME:</b>	<b>FIRST:</b>	<b>MIDDLE:</b>	<b>REFERRED BY:</b>
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**PRIMARY CARE DR. & PHONE #:**

<b>EMAIL ADDRESS :</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
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<b>RACE/ETHNICITY:</b> CAUCASIAN, BLACK, HISPANIC, ASIAN, NATIVE AMERICAN, OTHER _____	<b>LANGUAGE:</b> ENGLISH, SPANISH Other _____	<b>Birth Date:</b>	<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
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<b>ADDRESS</b>	<b>SOCIAL SECURITY #</b>	<b>HOME PHONE</b> ( )
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<b>CELL PHONE:</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
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<b>Occupation:</b>	<b>Employer:</b>	<b>Employer phone no.:</b> ( )
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**INSURANCE INFORMATION**

<b>PRIMARY INSURANCE CO :</b>	<b>MEMBER ID #:</b>	<b>GROUP #:</b>
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<b>SECONDARY INSURANCE CO :</b>	<b>MEMBER ID #:</b>	<b>GROUP #:</b>	
<b>Person responsible for bill:</b>	<b>Birth date:</b>	<b>Address (if different):</b>	<b>Phone :</b> (C) (H) ( )

**MEDICAL HISTORY**

Foot and Ankle Concerns: \_\_\_\_\_

PAST MEDICAL HISTORY: \_\_\_\_\_

PAST SURGERIES: \_\_\_\_\_

MEDICATION: (Dosage, Regimen) \_\_\_\_\_

PHARMACY NAME/LOCATION/PHONE # \_\_\_\_\_

ALLERGIES: (Drugs, Food, Latex) \_\_\_\_\_

**SOCIAL HISTORY**

**EXERCISE:**  Yes  No Type /Amount \_\_\_\_\_ **TOBACCO:**  Current  Never  Past Use/Quit Date \_\_\_\_\_ Type/ Amount \_\_\_\_\_

**ALCOHOL:**  Current: Occasional, Moderate, Heavy  Never  Past **DRUG USE:**  Current  Never  Past Use Type/Amount \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** \_\_\_\_\_

**IN CASE OF EMERGENCY**

<b>Name of friend or relative</b>	<b>Relationship to patient:</b>	<b>Home /Cell phone no.:</b> ( )	<b>Work phone :</b> ( )
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By signing this form, I give my consent to be treated by the medical provider of this practice. I allow the provider and staff of Dr. Donald Harrison to give me the needed medical treatment and services they recommend.. I understand treatment and services may include: lab tests, screening tests, diagnostic tests, imaging and routine exams. I understand that no promises have been made to me about the results of any treatment or service. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I understand that past due claims may be referred to collections.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Records Release Authority

I (Patient Name) \_\_\_\_\_ hereby request that you release to Foot and Ankle Institute of Maryland, Dr. Donald Harrison DPM, a report of my diagnoses, treatment, prognosis, and recommendations as well as other data pertinent to your treatment of me.

Patient Signature: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date: \_\_\_\_\_

Please fax Medical Records to Dr. Donald Harrison at 1-866-244-2416

**Medical Information Release Form (HIPAA Release Form)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_ Phone \_\_\_\_\_  
 Child(ren) \_\_\_\_\_ Phone \_\_\_\_\_  
 Other \_\_\_\_\_ Phone \_\_\_\_\_

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Cancellation, No Show and Rescheduling Policy

Dear Valued Patient,

Lately, we have been experiencing a high volume of missed scheduled appointments. We understand that there are times when you must miss or change an appointment due to emergencies or obligations for work or family and that delays can happen. However, when you do not call to cancel or reschedule you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

### **Cancelling your doctor's appointment:**

We require at least 24 hours advance notice to cancel or reschedule your doctor's appointment. If your appointment is not cancelled or rescheduled within this time, we reserve the right and will charge you a \$50.00 no show/late fee. Fee payable prior to next office visit. **This will not be covered by your insurance company.**

### **Cancelling your surgery appointment:**

We require at least 48 hours advanced notice to cancel or reschedule your surgery appointment. If your surgery is not cancelled or rescheduled we reserve the right to charge you a \$100.00 fee. **This will not be covered by your insurance company.** Due to the large blocks of time needed for surgery, last minute cancellations can cause problems and added expenses for the office and our ability to schedule you timely for needed treatment.

There is a charge for each form needed to be filled out

Disability, Specialty forms, FMLA, etc - ***\$35.00 for each form***

Return to Work/School and Medical Excuse slips no charge

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Completion of appointment with physician contractually obligates you to the  
aforementioned**