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Welcome to Casteel Foot & Ankle Center, Division of Stride Healthcare

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at (972) 412-6460 prior to your appointment or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where you want to be treated. We want to provide you with the most up to date information and treatment options regarding your foot care. We do appreciate and value the trust you have placed in us.

Casteel Foot & Ankle Center specializes in treatment of all foot and ankle disorders. Our doctor(s) and trained office staff work together to meet your podiatric needs five days a week. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient in a comfortable, private atmosphere. We assure you that we will do our best to give you total satisfaction.

We highly value the relationship with our patients, as well as value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Dr. Casteel and Staff!!!

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** if you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your primary Care Physician if required by your insurance plan.
- **Co-Pay** or **Deductible** is collected at the time of service.
- **Completed Patient Registration Package**
- **Driver's license or State Issued Photo ID**

Missed Appointments

For appointments that are missed or cancelled with less than 24 hours notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Returned Checks

All NSF checks will be charged a $35.00 processing fee. We will only accept cash or money orders to replace an NSF check. Your signature below signifies your understanding and willingness to comply with this policy.

Additional Fees:

- X-rays are property of Casteel Foot & Ankle Center, if you wish to receive copies of digital X-rays there will be a fee assessed of $15.00.
- Disability forms that need to be completed by our staff will incur a $35.00 fee.
- For copies of medical records, our office requires 7-day notice. There is a fee of $20.00 for up to 25 pages and $.05 cents for every additional page thereafter.

Disclaimer

We have verified your insurance coverage and at this time this is a quote of medical benefit coverage and not a guarantee of payment until the claim submitted has been reviewed. If your insurance company denies payment, you are responsible for the balance in full. You are also responsible for the deductible, co-payment, and or percentages where applicable.

_______________________________   _______________________

Signature   Date

Patient Information

First Name: __________________________ MI: ______ Last Name: _____________________________

Gender: Female______ Male______ DOB: _________ Email: _______________________________

Home Address: ____________________________________ City:____________________ State: ______

Home PH: ______________________ Mobile PH: ___________________ Work PH:__________________

Social Security Number: __________________________ Preferred Language: __________________

Race: Native Amer. ______ African Amer. _______ Pacific Island _______ Asian _______ White ______ Other

Primary Care Doctor: _________________ Referring Doctor: ________________Date Last Seen: ______

Emergency Contact:___________________ PH. Number: _________________ Relationship: __________

Marital Status: _____ Single _____ Married _____Divorced _____ Widowed _____ Separated

Insurance Policy Information

Primary Insurance: ________________ Policy #: __________________ Group# :___________________

Policy Holder Name: ______________________ DOB: _____________

Secondary Insurance: _________________ Policy #: _________________ Group#:__________________

Policy Holder Name: __________________________ DOB: _____________

Pharmacy Information: Name _______________________ Location: _________________________

Pharmacy PH. Number: _______________________ Pharmacy Fax: ______________________

_______________________________________ ___________________
Signature Date

Patient History Form

HT: __________ WT: __________ Shoe Size: __________
Current foot or ankle problem:____
____
When did the problem start and what has been done to treat it:____________________________________
____
Have you been under a physician's care in the past two years for this problem? If so, explain:__________
____
Name of former Podiatrist:___________________________________ Last seen:___________________
What condition(s) did they treat you for:____

Medical History

____ Diabetes
____ Gout
____ Heart Disease
____ High Blood Pressure
____ Stroke or Heart Attack
____ Stomach Ulcer/Reflex
____ Thyroid Disease
____ Liver Disease

____ Kidney or Bladder
____ Bleeding Disorders (Sickle Cell)
____ Anemia/Blood
____ Asthma/Bronchitis
____ Rheumatic Fever
____ Accident/Injuries
____ Immune Disease (AIDS or HIV)
____ Tuberculosis

____ Cancer
____ Epilepsy/Seizures
____ Depression or Anxiety
____ PTSD
____ Vascular/Circulatory Disease
____ Arthritis
____ Hepatitis A,B,C
____ Other (explain below)

**Please briefly explain "Positive" responses to the above condition(s): ______________________________
____

Medications: (Please include dosage and frequency taken)

1. ____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

Allergies: (Penicillin, Novocain, tape, food, seasonal, etc.)

1. ____ 3. ____
2. ____ 4. ____

Surgeries and Hospitalization: (Describe procedure/complications and year conducted)

1. ____ 3. ____
2. ____ 4. ____

Social History:

Occupation:____________________ Tobacco: How much/how long?__________________________
Alcohol use:____________________ Illicit Narcotics: What kind/how long?______________________

Family History: (Diabetes, Heart disease, Cancer, Gout, Foot disorders)

____

_______________________________________ _______________________

Signature Date

Personal Representative Authorization for Medical Release Form

Under HIPPA requirements, we are not allowed to discuss any of your health information with anyone else without consent.
I authorize this facility to speak with the following family members or the individual(s) listed below about:
______ All medical information, to include but not limited to; appointments, billing, test results, diagnosis, and procedures.
______ Only the following types of information: ____

The above medical information shall only be released to the following person(s):

1. ________________________Relationship: ___________________ Phone number: __________________
2. ________________________Relationship: ___________________ Phone number: __________________
3. ________________________Relationship: ___________________ Phone number: __________________

By signing below, I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPPA) and that I may request a copy of this Act at any time.

Name (**PRINTED**) ___________________________

Signature _________________________________

Date ______________________________________