

PATRICK M. FARRELL, D.P.M., INC.

11551 S. Fortuna Rd. Suite A, Yuma, AZ 85367

928-342-1588 FAX 928-342-2289

PATIENT REGISTRATION

Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex: M F Marital Status: S M W Sep D

Local Address _____ Apt/Space # _____

City _____ State _____ Zip _____ Phone # _____

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____ or Retired

Employer's Address _____

Business Phone # _____ Page # _____ Cell Phone # _____

Emergency Contact _____ Phone # _____ Relationship _____

Spouse's Name _____ Spouses Occupation _____ or Retired
or Parent's Name _____ or Parent's Occupation

Spouse's Employer _____ Business Phone # _____
or Parent's Employer

How did you hear about us? (circle all that apply) Doctor refer (name) _____

Qwest Phonebook Greater Yuma Phonebook MCAS Phone Directory Street Sign/Drive By

Insurance Book ER/Urgent Care HealthConnections Patient refer (name) _____

Welcome Back Bash Lecture Newspaper Article Other _____

IF YOU ARE A WINTER VISITOR, COMPLETE THE INFORMATION BELOW

Summer Address _____ Apt/Space # _____

City _____ State _____ Zip _____ Phone # _____

FOR WORKER'S COMPENSATION, COMPLETE THE INFORMATION BELOW

Date of Injury _____ Claim # _____ Adjuster's Name _____

Insurance Name _____ Phone# _____ Ext # _____

Insurance Address _____

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INSURANCE ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment from my insurance company be paid directly to Patrick M. Farrell, D.P.M., on any bill for services furnished to me by the physician. I authorize the release of any medical information necessary to determine benefits payable for these services provided by Dr. Farrell. I also authorize Dr. Farrell to treat me.

I understand that I am financially responsible for all charges incurred including office expenses, lab fees, pathology fees and outpatient procedure charges. This is to include any and all charges not covered by my medical insurance. I also understand that if my insurance requires a referral, I am responsible for getting the referral and keeping up with the expiration dates.

Patient's Name (Please print)

Parent or Guardian's Name

Patient or Guardian Signature

Date

IF YOU HAVE NOT GIVEN US A COPY OF YOUR INSURANCE CARD, PLEASE COMPLETE THE INFORMATION BELOW:

Primary Insurance Company Name, Mailing Address and Phone Number

Name of Insured, SS# or ID#, Group # or Policy # and Insured's Employer

Secondary Insurance Company Name, Mailing Address and Phone Number

Name of Insured, SS# or ID#, Group# or Policy# and Insured's Employer

Record ID # 149951

DOCUFORMS POD-2010 Page 1 of 2 Confidential Office Medical Record

Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct #

Form with fields for First Name, MI, Last Name, Your type of Job Activity / Occupation, Soc. Sec. No., Sex, Age, Birth Date, Shoe Size, Weight, Height, and various checkboxes for address preferences.

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Form with multiple checkboxes for medical history including Warts, Athlete's Foot, Ingrown nails, etc., and questions about shoe inserts and orthotics.

Form with checkboxes for family medical history (Diabetes, Arthritis, Stroke, Cancer, etc.) and pregnancy status.

Form with checkboxes for current symptoms (Does foot pain limit your desired activities?) and a list of conditions treated (Stroke, Heart Attack, etc.).

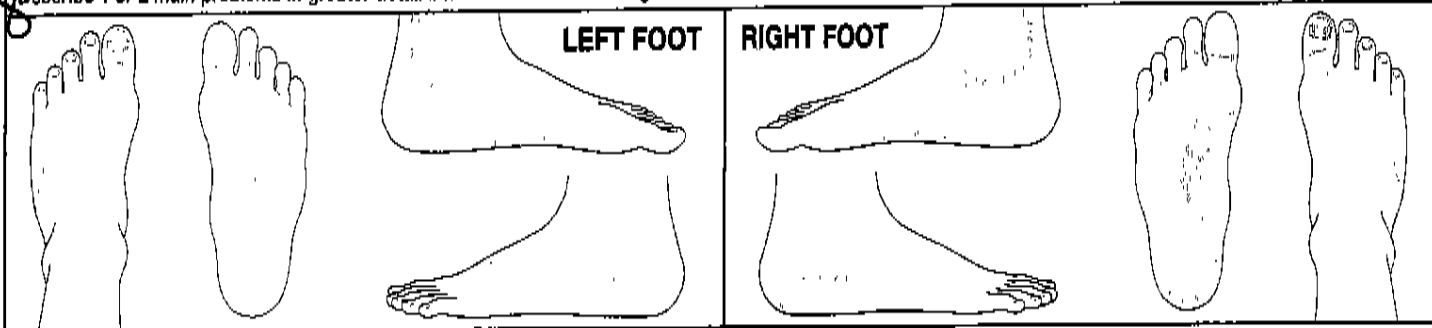
Form for listing medications (List: Medications Dose? How Often? For Treatment of?) and allergies (Allergies: Is there a history of skin reaction...).

INITIAL HISTORY UPDATE OF HISTORY TAKEN PATIENT HISTORY AS OF

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3 PATIENT'S CURRENT CHIEF COMPLAINTS CC/HPI Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



1 Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡
 My first problem is ... On Left foot On Right foot On Both feet.
 It causes me difficulty: walking, wearing shoes, and/or It ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
 Shooting Pain
 Throbbing Pain
 Sharp Pain
 Burning Pain
 Itching
 Aching Pain
 Tenderness
 Dull Pain
 Tingling
 Numbness

How long ago did the problem (pain) start?:
 _____ days, _____ weeks, _____ months, _____ years ago

The pain from my problem occurs:
 while walking and/or while not walking
 and/or: _____

Previous medical treatment(s) or home remedies:

2 Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡
 My second problem is ... On Left foot On Right foot On Both feet.
 It causes me difficulty: walking, wearing shoes, and/or it ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
 Shooting Pain
 Throbbing Pain
 Sharp Pain
 Burning Pain
 Itching
 Aching Pain
 Tenderness
 Dull Pain
 Tingling
 Numbness

How long ago did the problem (pain) start?:
 _____ days, _____ weeks, _____ months, _____ years ago

The pain from my problem occurs:
 while walking and/or while not walking
 and/or: _____

Previous medical treatment(s) or home remedies:

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/Primary	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcal Eval <input type="checkbox"/> Consult
Specialist	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcal Eval <input type="checkbox"/> Consult
Other Podiatrist	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcal Eval <input type="checkbox"/> Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

Patient was assisted in completion of this record by or was unable to complete without the help of: _____

Translation was done by _____ in Spanish, _____

Additional Information† obtained from Family/Care givers and/or Physician(s) _____

Lab Reports† and/or Previous Medical Records† were reviewed. X-rays† brought by patient from _____ were reviewed.

† Elaborations: _____

I have reviewed the information provided above _____ My annotations to patient's entries are marked in: _____ (INK COLOR)

Doctor's Signature **PA** _____ Date _____ See Additional Documentation

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PATIENT HISTORY
 Patient Name: _____
 Last, First, Middle: _____

SSN: _____
 Sex: _____
 Age: _____
 DOB: _____