1748 Jancey St Ste A, Pittsburgh, PA 15206 1432 Lincoln Way, White Oak, PA 15131 P: 412-990-3668 F: 724-273-8236

Fourth River Foot and Ankle, PC- Vincent Vess, D.P.M.

New Patient Registration Form

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible. If you have any questions, please contact the office. Thank you and we look forward to seeing you!

Patient Information

First Name:_____ MI:____ Last Name:_____

DOB:_____ Sex: _____ SSN:_____

Mailing Address:

_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email Address:_____

Emergency contact and phone:_____

Additional Information

Race: (please circle)

American Indian or Alaska Native Asian Black or African American

Hispanic Native Hawaiian or Pacific Islander White

Other Decline

Ethnicity : (please circle)

Hispanic or Latino Not Hispanic or Latino Decline

How did you hear about us?_____

Patient Name:_____

Primary Care Physician:

Name: _____ Phone Number: _____

Pharmacy:

Name: _____ Phone Number: _____

Medical History

Please list current or past medical conditions (diabetes, heart disease…):

Please list all medications you are currently taking (including over the counter and vitamins/supplements) *if you have a list of medications, we can make a copy

Surgical History

Please list previous surgeries:

Are you on Blood thinners? Y/N

Allergies to medications (list):

Social History

Do you smoke? (please circle)
Yes (how much_____) No Socially

Do you drink alcohol? (please circle)
Yes (how much_____) No Socially

Patient Name:_____

Please describe your current problem (foot pain, nail issue, hammertoe etc):

When did the problem start?

Previous Treatment?

Review of Systems

Please circle any issues you are having

Vision problems Ear/Nose Throat Heart issues/palpitations/swelling

Breathing problems/shortness of breath/coughing blood genitourinary blood/anemia

Abdomen/heartburn/difficulty swallowing/nausea/vomiting Skin issues Nerve issues/numbness

Musculoskeletal/joint pain Circulatory Problems

Signature:_____ **Date:**_____

I certify that the above information is correct. In order to substantiate claims submitted to my insurance company, I authorize holders of medical and billing information to release needed information about me (or my child) for Medicare or insurance claims. Dr. Vess can share information with but not limited to: hospitals, diagnostic testing centers, physicians, home health agencies, pharmacies, therapy/rehab centers, attorneys and POA's. Medical information is included but not limited to: doctor's orders, RX requests, account information, conditions, diagnoses, procedures and results of tests ordered, and authorize payment of medical benefits to this office. I understand that I will obtain authorization, if necessary, prior to services: otherwise I accept the financial responsibility. I understand that I am responsible for deductibles, copayments, and or co-insurance amounts AT THE TIME OF SERVICE. I authorize this office to send and receive medical information about me (or my child) and allow doctors and staff to discuss medical information with my doctors and personnel involved in my care. I understand that it may be necessary to transmit medical information electronically and I authorize you to do so. If this information is received by another party in error, I absolve Dr. Vincent Vess or any and all liability related to such transmission of said information. I permit a copy of this authorization to be used in place of the original. I understand that this authorization can be revoked by me at any time in writing.