**History and Physical**

Name: ___________________________________________

Height: _____  Weight: _____  Shoe Size: ______

List of Current Medications:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Allergies:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

**Medical History:**
- Allergies
- Back Pain
- Anemia
- Blood Clots
- Anxiety
- Bleeding Problems
- Arthritis
- Breathing Problems
- Asthma
- Cancer (type)
- Circulation Problems
- Depression
- Diabetes Type 1
- Heart Murmur
- Heart Disease
- Emphysema
- Fibromyalgia
- Gout
- Heart Murmur
- High Blood Pressure
- HIV
- IBS
- Kidney Disease
- High Cholesterol
- Mental Illness
- Neuropathy
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Restless Leg Syndrome
- Sleep Apnea
- Skin Disorders
- Stroke

**Are You Pregnant?**  □ Yes  □ No  **Are You Nursing?**  □ Yes  □ No

**Surgical History:**
- **NONE**
- Adenoids
- Angioplasty
- Appendix
- Cataracts
- Colonoscopy
- C-Section
- Gallbladder
- Heart Bypass
- Heart Stent
- Hip Replacement
- Teeth
- Tonsils
- Tumor Removal
- Other:

Have you ever had any surgical procedure on your foot/ankle?  □ Yes  □ No
If yes, please describe: ________________________________________________________________

Do you have any artificial joints?  □ No  □ Yes, Where? _______________________________

Do you have an artificial heart valve?  □ No  □ Yes
Family History: Is there any family history of the following? Please specify whether it is your mother, father, or other family member.

- Arthritis
- Asthma
- Bleeding Problems
- Blood Clot
- Cancer
- Diabetes Type 1
- Diabetes Type 2
- High Blood Pressure
- Heart Disease
- Kidney Disease
- Liver Disease
- Other (specify) __________
- Blood Clot
- Bleeding Problems
- Cancer
- Diabetes
- Other (specify) __________
- High Blood Pressure
- Heart Disease
- Kidney Disease
- Liver Disease
- Other (specify) __________

Social History:
Do you drink alcohol? □ No □ Rarely □ Socially □ Everyday
Do you drink caffeinated beverages? □ No □ Yes, How much? __________________________
What is your occupation? ____________________________________________________________
Do you exercise regularly? □ No, I do not. □ Yes, I do the following regular exercise: ____________________________________________________________
Substance Abuse: □ No □ Yes, I have a current substance abuse problem. Please specify: __________________________
Do you smoke? □ No □ Yes □ Former
If yes, how many packs per day? □ ½ □ 1 □ 2 □ 3 □ 4 □ How long? __________________________

Review of Systems: (Please check the box if you currently have any of these symptoms or check “NONE”)

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
<th>Integumentary</th>
<th>Musculoskeletal</th>
<th>Neurological</th>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Ankle Swelling</td>
<td>o Abdominal Pain</td>
<td>o Blood in Urine</td>
<td>o Athletes Foot</td>
<td>o Ankle Pain</td>
<td>o Numbness</td>
<td>o Chest Pain</td>
</tr>
<tr>
<td>o Cold Feet/Hands</td>
<td>o Blood in Stool</td>
<td>o Decreased Urination</td>
<td>o Callus/Corns</td>
<td>o Arch Pain</td>
<td>o Paralysis</td>
<td>o COPD</td>
</tr>
<tr>
<td>o Constipation</td>
<td>o Constipation</td>
<td>o Decreased Appetite</td>
<td>o Cracked Heels</td>
<td>o Ball Pain</td>
<td>o Seizures</td>
<td>o COPD</td>
</tr>
<tr>
<td>o Leg Pain</td>
<td>o Decreased Appetite</td>
<td>o Excessive Urination</td>
<td>o Ingrown Toenail</td>
<td>o Bottom of Foot Pain</td>
<td>o Seizures</td>
<td>o COPD</td>
</tr>
<tr>
<td>o Leg Swelling</td>
<td>o Diarrhea</td>
<td>o Kidney Stones</td>
<td>o Keloids</td>
<td>o Flat Feet</td>
<td>o Tingling/Burning</td>
<td>o Wheezing</td>
</tr>
<tr>
<td>o Palpitations</td>
<td>o Heartburn</td>
<td>o Incontinence</td>
<td>o Nail Changes</td>
<td>o Heel Pain</td>
<td>o Tremors</td>
<td>o NONE</td>
</tr>
<tr>
<td>o Vascular Disease</td>
<td>o Vomiting</td>
<td>o Painful Urination</td>
<td>o Ulcers</td>
<td>o Toe Pain</td>
<td>o Weakness</td>
<td></td>
</tr>
<tr>
<td>o NONE</td>
<td>o Ulcers</td>
<td></td>
<td>o Warts</td>
<td>o Top of Foot Pain</td>
<td>o</td>
<td></td>
</tr>
</tbody>
</table>

How long? ________________
What is the reason for your visit today?

On a scale of 1-10, how would you rate your pain (1 being no pain to 10 being the worst): 1 2 3 4 5 6 7 8 9 10

How long has this bothered you?

What treatments have you tried and have they been effective?

The pain quality is: burning constant dull sharp shooting throbbing tingling tearing

Other:

What make the pain worse? Running Walking Standing Certain Shoes Elevation Touching/Rubbing

Other:

Have you experienced any trauma or injury to the area?

Is this condition the result of an event at work? □ No □ Yes

If yes, have you notified your employer and the worker’s compensation liaison at your place of employment?

What is their contact information?

Please circle where on your feet/ankles you are having pain.

Please READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ___________________________ Date: ___________________________
Patient Information

<table>
<thead>
<tr>
<th>Date: ______________________</th>
<th>SSN: ______________________</th>
<th>Birth Date: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name: ______________________</th>
<th>Last Name: ______________________</th>
<th>First Name: ______________________</th>
<th>Initial: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: ______________________</th>
<th>City: ______________________</th>
<th>State: ______________________</th>
<th>Zip: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home #: ______________________</th>
<th>Cell #: ______________________</th>
<th>Email: ______________________</th>
</tr>
</thead>
</table>

| Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated |
|-------------------------------|-----------------------------|--------------------------------|-------------------------------|

<table>
<thead>
<tr>
<th>Employer: ______________________</th>
<th>Business Phone: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact: ______________________</th>
<th>Phone #: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Who is your Primary Care Doctor?: ______________________</th>
<th>Date last seen?: ______________________</th>
</tr>
</thead>
</table>

| Who may we thank for referring you?: ______________________ |
|--------------------------------|-----------------------------|

| How did you hear about Feet First Podiatry?: ______________________ |
|--------------------------------|-----------------------------|

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Insured Information

Primary Insurance:

<table>
<thead>
<tr>
<th>Subscriber Name: ______________________</th>
<th>Sex: ☐ Male ☐ Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subscriber DOB: ______________________</th>
<th>Subscriber SSN: ______________________</th>
</tr>
</thead>
</table>

| Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other |
|------------------------------------------------|---------------------|

<table>
<thead>
<tr>
<th>Phone #: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy ID: ______________________</th>
<th>Group ID: ______________________</th>
</tr>
</thead>
</table>

Secondary Insurance:

<table>
<thead>
<tr>
<th>Subscriber Name: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subscriber DOB: ______________________</th>
<th>Subscriber SSN: ______________________</th>
</tr>
</thead>
</table>

| Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other |
|------------------------------------------------|---------------------|

<table>
<thead>
<tr>
<th>Phone #: ______________________</th>
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<tr>
<th>Policy ID: ______________________</th>
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</tr>
</thead>
</table>

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I hereby authorize payment directly to Feet First Podiatry of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I understand that I am financially responsible for any collection fee should I default on any patient balances. I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: ______________________ | Date: ______________________
LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician’s schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone including the patients. We strive to see every patient as close to their appointment time as possible.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

We ask that you please be courteous of your provider’s valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

__________________________________________
Patient Name (please print)

__________________________________________
Parent or Authorized Representative (If Applicable)

__________________________________________  _____________
Signature                                       Date
The physicians and staff of Feet First Podiatry want you to completely understand our financial policies.

Payment of Services
Payment for services rendered is ultimately the patient's responsibility. Your insurance policy is a contract between you and your insurance company. It is YOUR responsibility to give us correct information about your insurance company. You must comply with the rules of your insurance company such as obtaining a valid referral form. Plan eligibility for procedures does not always confirm certification, authorization or payment of service. We will file your insurance claim, but for claimed denied because of failure to comply with the insurance company requirements, you will be responsible for paying the denied amount. For patient balances and self-pay accounts, we accept cash, Visa, Discover and MasterCard. In the event of non-payment, you will be responsible for any collection and/or legal fees associated with the collection of the balance due.

Co-Payments and Deductibles
Your insurance company requires you to pay your co-pay at the time of the service. Failure to pay is a violation of your contract with your insurance company. Please do not ask us to bill you for a co-pay. If you do not have your co-pay with you, we are happy to reschedule your appointment at the next available opening. The deductible amounts are always the patient responsibility. Until the deductible amount is satisfied, your insurance is not responsible for reimbursement or payment.

Non Covered Services
Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. We recognize government plans require an "Advance Beneficiary Notice" which we will provide.

Workers' Compensation Claims
We file workers compensation claims, however:
- Your employer must approve treatment and the bill for services rendered must be sent to your employer or their Workers' Compensation carrier.
- If your employer does not approve treatment and YOU SELECT US FOR TREATMENT, you will be responsible for the bill.

Lawsuits and Third Party Billing
We do not accept third party billing. You are responsible for payment of our regular fees at the time of service unless other arrangements are made in advance with our financial coordinator.

No Insurance Coverage
If you do not have insurance coverage, we expect payment in full before service is rendered. In certain circumstances, payment plans may be made in advance of your visit. If you default on your promised payment, our policy is to refer your account to a collection agency.

Physician Non Participation in Your Insurance Plan
We participate in numerous insurance plans. However, there are plans with which we do not participate and therefore you would be responsible for the difference between the "Out of Network" payment and our billed charges. If you have questions, please contact your insurance plan.

I have read and understand and practice's financial policy and I agree to be bound by its terms.

____________________________________________________
Signature of patient (or responsible party)   Date