Feet First PODIATRY

Patient Information

Date:_____ **SSN:**_____ **Birth Date:** _____

Name:_____
Last Name First Name Initial

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____ **Email:**_____

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

Ethnicity : Caucasian African American Asian Latino Other : _____

Employer: _____ **Business Phone:**_____

Emergency Contact: _____ **Phone #:**_____

Who is your Primary Care Doctor? (First/last name) _____

Phone number : _____ **Date last seen :** _____

Who may we thank for referring you?_____

Insured Information

Primary Insurance:_____

Subscriber Name: _____ Sex:☐Male☐Female

Subscriber DOB: _____ Subscriber SSN: _____

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

Secondary Insurance:_____

Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____

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

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 understand the Notice of Privacy Practices.

_____ _____
Signature of Patient or Authorized Representative Relationship to Patient (if applicable)

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:_____

History and Physical

Feet First PODIATRY

Name:_____

Height: _____ Weight: _____ Shoe Size: _____

PHARMACY : _____
PHONE #: _____

List of Current Medications:

_____
_____
_____
_____

Allergies - include reaction :

_____
_____

Medical History:

o Allergies	o Anemia	o Anxiety	o Arthritis	o Asthma
o Back Pain	o Blood Clots	o Bleeding Problems	o Breathing Problems	o Cancer (type) _____
o Circulation Problems	o Depression	o Diabetes *Type 1 Type 2*	o Emphysema	o Fibromyalgia
o Gout	o Heart Disease	o Heart Murmur	o Hepatitis	o High Cholesterol
o High Blood Pressure	o HIV	o IBS	o Kidney Disease	o Liver Disease
o Mental Illness	o Neuropathy	o Psoriatic Arthritis	o Rheumatoid Arthritis	o Restless Leg Syndrome
o Sleep Apnea	o Skin Disorders	o Stroke		o Other (specify) _____ _____ _____

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

Surgical History:

o **NONE**	o Adenoids	o Angioplasty	o Appendix	o Cataracts
o Colonoscopy	o C-Section	o Gallbladder	o Heart Bypass	o Heart Stent
o Hip Replacement	o Teeth	o Tonsils	o Tumor Removal	o 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 Type 2*
- ○ 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? _____

Marital Status : _____

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

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

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?

_____

_____

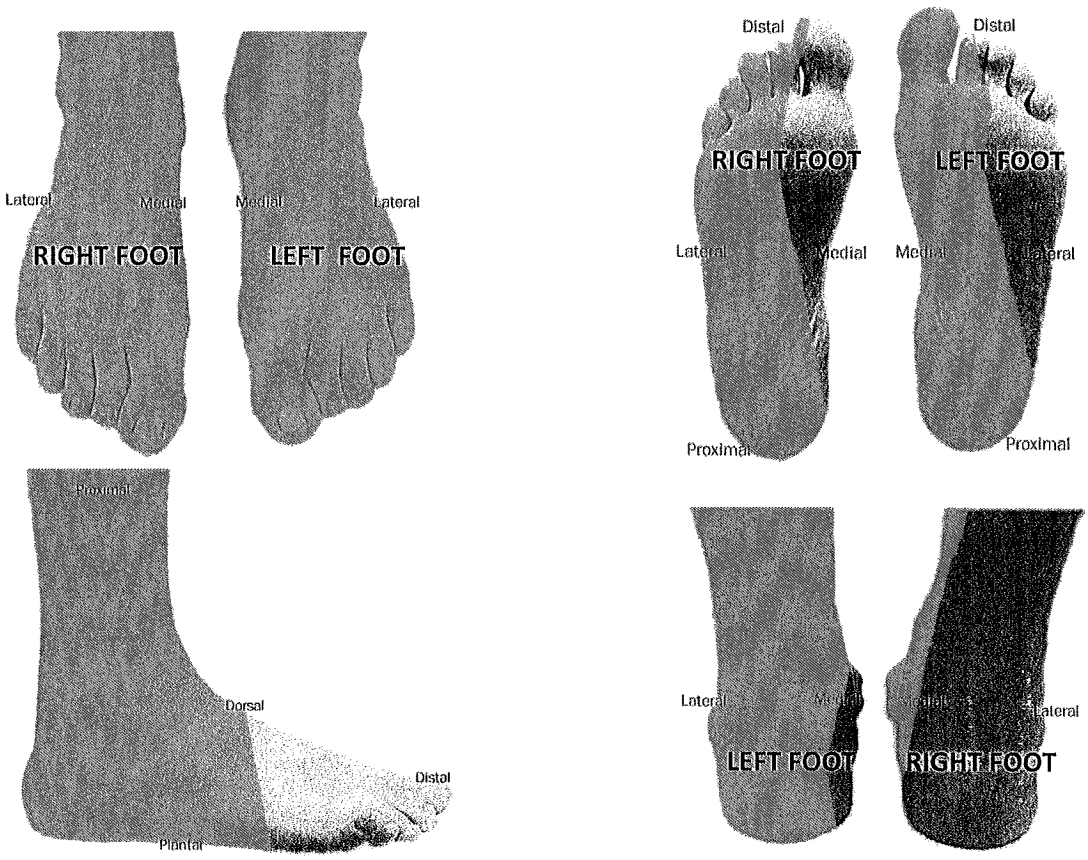
Is this condition the result of an event at work? No Yes

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:**_____

Financial Policies
Feet First Podiatry

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 claims 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. If you are using a debit or credit card there will be a 4% convenience fee added to your total. 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.

Missed Appointments
Kindly give the office a 24-hour notice if you are not able to make it to your appointment. There is a 15-minute grace period for you to arrive and you may be asked to reschedule. There will be a charge of $25 for any missed appointment and payment will be required before your next scheduled appointment.

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. If you have over $500 remaining of your deductible we will require you to pay for any additional services at the time of your visit.

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.

FMLA/Disability/ Leave Paperwork
Our office does charge a fee for each request. $25 charge for 1-3 page forms and $40 charge for anything over 3 pages. Payment will be required prior to service completion.

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 the practice's financial policy and I agree to be bound by its terms.

_____ _____

Signature of patient (or responsible party) **Date**

Documentation for flu, pneumonia and care plan

Medicare is requiring all physicians to start collecting the information below. We at Feet First Podiatry must comply with the program or be penalized for non-participation. We appreciate your cooperation.

(FOR MEDICARE PATIENTS ONLY)

Name : _____ Date : _____

Additional Patient History Information

Have you received a flu vaccination for the current season? YES or NO

If No, what was the reason? ____ Patient allergy ____Patient declined ____ Vaccine unavailable

Are you a Diabetic? YES or NO If Yes, what was your most recent HBa1C? _____

Treating Physician of your Diabetes _____

Has your doctor prescribed medication to treat high blood pressure (hypertension)? YES or NO

Are you a smoker? YES or NO

For Patients 65 years of age or older

Do you have a living will or someone to make decisions on your behalf? Yes____ No____

Have you had a Pneumonia Vaccination? Yes____ No____