PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/____/____

Patient Name: Last_____ M_____ First_____ Date of Birth ___/___/____

Sex: M F **Social Security #:** _____-_____-_____ **Primary Language:**_____

Ethnicity (Please Circle)**:** Hispanic or Latino, Non-Hispanic or Latino

Race (Please Circle): American Indian or Alaska Native, Asian, African American, Caucasian

Native Hawaiian or Other Pacific Islander

Current Shoe Size: _____ Height:_____ Weight: _____

Home Address_____City/State:_____Zip:_____
Primary Phone Number:_____ Secondary Phone Number:_____
Email: _____
Employer: _____ Occupation: _____
Emergency Contact:_____ Relationship:_____ **Phone:_____**
Primary Care Doctor:_____ Phone: _____
Referring Doctor: _____ Phone: _____
Pharmacy: _____ Location: _____ Phone: _____
How Did You Learn About our Office:_____

Who is Responsible for Payment:_____ Relationship:_____
Address:_____City/State:_____ Zip:_____
Phone:_____

Is There a Family Member or Other Person You Would Like For Us to Share Your Medical Information With?
Name(s)_____ Relationship:_____

INSURANCE INFORMATION

Primary Insurance Company: _____
Insured Name:_____ Date of Birth: _____ Employer_____
Secondary Insurance Company: _____
Insured Name:_____ Date of Birth: _____ Employer_____

SOCIAL HISTORY

Marital Status (Please Circle): Single Married Partnered Separated Divorced Widowed
Who Do You Live With:_____
How Many Children: _____
Use of Tobacco (Please Circle): Never, Quit, How long ago_____ Current Smoker, Packs per Day___
Use of Recreational Drugs (Please Circle): Never, Quit, How long ago_____ Type: _____
Use of Alcohol (Please Circle): Never, No Longer Use, History of Abuse,
Current Use Type: _____ Frequency (Please Circle): Rare Occasional Moderate Daily

FAMILY HISTORY: PLEASE CIRCLE MOTHER OR FATHER

Diabetes **M/F** Cancer **M/F** Heart Disease **M/F** High Blood Pressure **M/F** Stroke **M/F**
Coronary Artery Disease **M/F** Thyroid Disease **M/F** Rheumatoid Arthritis **M/F**
Other: _____

YOUR MEDICAL HISTORY

Allergies (Please Circle): No Known Allergies Tape Latex Shellfish Iodine
Medication: _____
Anesthesia: _____
Other: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): PLEASE BRING A LIST WITH YOU

NAME DOSE HOW OFTEN DO YOU TAKE IT?

_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES

TYPE OF SURGERY DATE

_____
_____
_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS

REASON FOR HOSPITALIZATIONS DATE

_____
_____
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

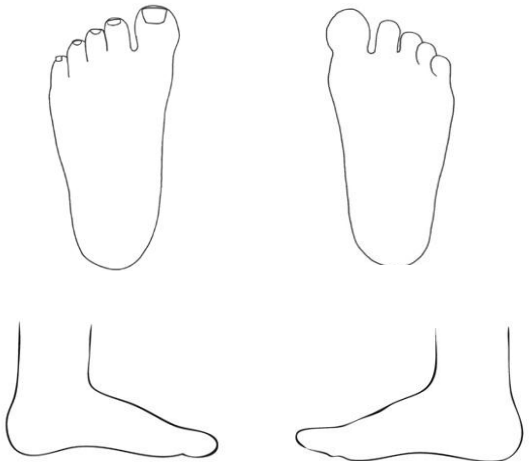
ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
OTHER CONDITIONS:										

CURRENT PROBLEM

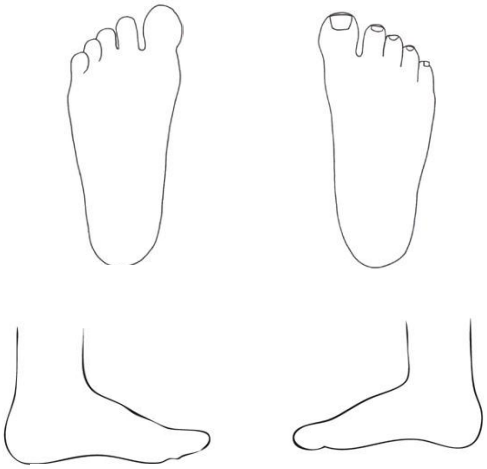
What specific problem brings you into our office today? _____

Where is the pain/problem located? Please indicate on the pictures below.

Left Foot



Right Foot



When did your problem or pain first begin? _____ Days/Weeks/Months/Years

How would you describe your pain (Please Circle): Sharp Shooting Dull Aching Burning Itching Stabbing Tingling Swollen Tender Throbbing Other: _____

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

What makes your pain or problem feel worse? (Please Circle)

Walking Standing Daily Activities Resting Dress Shoes Running Sitting Sleeping Sports Driving Closed Toe Shoes Walking Stairs Working Exercise Other: _____

What treatments have you tried for this problem? _____

Was this problem caused by injury (Please Circle) Yes No

If yes, please describe: _____ Was it a work-related injury? Yes No

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

Financial Policy

Welcome and thank you for choosing Foot First Podiatry for your Podiatric foot care needs. In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a moment to read our Financial Policy, fill out the demographic health history forms for your medical file. If at any time you have a question regarding our office policies do not hesitate to contact us and we will be happy to help you.

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and HMO plans in our area. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help.

Patient Billing

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you have an unmet deductible we pre-collect 50% of the charges incurred that your insurance will apply towards your deductible.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

Complete payment for all podiatry soft goods, medical products and supplies are due at the time they are dispensed.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Appointment Cancellation Policy

A 24-hour notice is requested for cancellations of appointments. If you fail to show for an appointment you personally may be charged a $25.00 no-show fee. We will try to accommodate you in rescheduling your appointment as soon as possible.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Signature of Patient/Responsible Party: _____

Name of Patient/Responsible Party:_____Date:_____