MEDICAL HISTORY AND PATIENT INFORMATION

Please print clearly!

NAME:___________________________________ Date of birth: ________________ Sex: M F

ADDRESS: ________________________________ SSN: ________ - ______ - ____________

^^^ -required to verify insurance

____ Driver's License: State _____ #: ____________________

EMAIL*:___________________________________

^^^required for all office communication

MOBILE PHONE: ___________________________

HOME PHONE: ____________________________

PRIMARY CARE PHYSICIAN: ________________________________ DATE OF LAST VISIT: _________________

Who referred you to our office? ____

IN YOUR WORDS, WHAT PROBLEM ARE YOUR HAVING TODAY ? _____________________________________

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BEST ESTIMATE FOR YOUR: HEIGHT: __________________ WEIGHT: _________________

ALLERGIES: Are you allergic to any of the following? [ ] I have no known allergies

[ ] Aspirin [ ] Latex [ ] Penicillin [ ] Sulfa [ ] Eggs
[ ] Iodine [ ] Local anesthetics [ ] Codeine [ ] Tetracycline [ ] Bee stings
[ ] Cipro [ ] Clindamycin [ ] Other: _______________

MEDICATIONS: Please list any medications and dosages taken, include over the counter medications, vitamins, & herbal medications

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> PREFERRED PHARMACY: ____

MEDICAL PROBLEMS: Please check box if you are **currently** being treated for any of the following:

[ ] Blindness [ ] Asthma [ ] Arthritis [ ] Hypothyroidism
[ ] Cataracts [ ] Bronchitis [ ] Gout [ ] Thyroid disease
[ ] Glaucoma [ ] COPD [ ] Bone/Joint injury [ ] Diabetes type (1) [ ] type (2) [ ]
[ ] Seasonal allergy [ ] Pneumonia [ ] Dermatitis [ ] Anemia
[ ] Aneurysm [ ] Cirrhosis [ ] Seizure [ ] AIDS/HIV
[ ] Chest pain/ Angina [ ] Reflux/GERD [ ] Migraine headaches [ ] Hepatitis
[ ] High blood pressure [ ] Gall bladder disease [ ] UTI [ ] Tuberculosis
[ ] High cholesterol [ ] Ulcer [ ] Kidney disease [ ] Liver disease
[ ] Hernia [ ] Other medial problems not listed: _________________
[ ] I do not have significant medical problems.

MEDICAL HISTORY: Please check if you have been treated for the following:

[ ] Stroke [ ] Heart attack [ ] Blood clots/ DVT [ ] Cancer _______________________.

PRIOR SURGERIES: Please list any surgeries, including previous foot surgery.

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SOCIAL HISTORY:

[ ] Never smoked [ ] Do not drink alcohol [ ] Other
[ ] Everyday smoking [ ] Daily alcohol [ ] Explain: _________
[ ] Former smoker [ ] Occasional alcohol

FINANCIAL POLICY AND PATIENT PAYMENT AGREEMENT

Our financial relationship is with **you**, the patient.

You, not your insurance company, are ultimately responsible for the payment of all fees charged.

For your convenience we accept credit card payment for amounts greater than $5.00.

We request that you pay the patient responsibility portion at the time of service. Credit cards may be kept on file for payment of deductible, co-insurance, or fees assigned to patient responsibility by your insurance coverage.

If we cannot verify eligibility from your insurance carrier, payment is due in full at the time of treatment.

Our office does not extend payment plans. You are responsible for all collection fees and any other expenses incurred to collect unpaid accounts. Outstanding balances greater than 90 days will be sent to professional collection agents and the patient will be discharged from the practice.

Failure to keep your health insurance current, including coordination of benefits with multiple insurance companies, results in patient responsibility of payment. Account balance/deductible not settled at the time of service may be billed to card on file.
Any remaining balance after your insurance company issues payment is due upon receipt of your billing statement.

There will be a $20.00 charge for a missed appointment or for failing to cancel 48 hours in advance.
Any cancellation or reschedule made less than 2 business days will result in a cancellation fee. Anything less than 2 business days does not allow adequate time to call patients on our waiting list to offer sooner appointments. _________. (initial)
In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

I certify the above information is true and correct to the best of my knowledge.
I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient signature: ________________________________ **Date**: ____________________

REQUIRED FOR DEPENDENTS:

Name of **responsible party** if other than patient: ________________________ Relationship: ____________________

Signature of responsible party: ______________________ Date: ____________________

PRIMARY INSURANCE ACCOUNT: [ ] Patient [ ] Parent [ ] Spouse [ ] Guardian [ ] other __________________

> **If other than Patient then complete for the primary account:**

Insurance company/plan : ___________________________ **Member ID number**: ________________________________

NAME:__________________________________ Date of birth: _______________ Sex: M F

ADDRESS: ______________________________ SSN: ________ - ______ - ___________
^^^ -required to verify insurance

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