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 ? ___________________________________
____

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

____
____
____

> PREFERRED PHARMACY: ____

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

[ ] Blindness [ ] Asthma [ ] Arthritis [ ] Hypothyroidism
[ ] Cataracts [ ] Bronchitis [ ] Rheumatoid arthritis [ ] Thyroid disease
[ ] Glaucoma [ ] COPD [ ] Gout [ ] Diabetes type (1) [ ] type (2) [ ]
[ ] Seasonal allergy [ ] Pneumonia [ ] Bone/Joint injury [ ] 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 [ ] Dermatitis [ ] 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.

____
____

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.

It is a courtesy to the patient for our billing department to submit your insurance for payment, however, after a certain time period of non-payment or denials from your insurance company it becomes the patient's responsibility to ensure that our fees are paid and the patient takes up the matter themselves with their insurance company.

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

We request that you pay your estimated 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. I understand that benefits quoted to me are just an estimate and I understand that I am financially responsible for all charges whether or not paid by my medical insurance.

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

A valid email is required for automated billing.

A mailed invoice may be requested. There is $2.00 fee is charged for EACH invoice mailed…

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 failing to keep an appointment or cancel your appointment 24 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)

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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