Welcome To Our Office

Please Print

1 Patient Information

Date _____ Home Phone ( ) _____ E-mail _____
Last Name _____ First Name _____ Middle Initial _____ Sex ❑ M ❑ F
Street _____ City _____ State ____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ___/___/___
Marital Status _____ Children? _____ Ages _____
Employer _____ Phone ( ) _____Ext.____
Street _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work? ❑ Y ❑ N Work Hours _____

Spouse/Domestic Partner Information (If appropriate)

Home Phone ( ) _____
Last Name _____ First Name _____ Middle Initial _____ Sex ❑ M ❑ F
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ___/___/___
Employer _____ Phone ( ) _____Ext.____
Street _____ City _____ State _____ Zip _____

Financially Responsible Party (If different from patient)

Home Phone ( ) _____
Last Name _____ First Name _____ Middle Initial _____ Sex ❑ M ❑ F
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ___/___/___
Employer _____ Phone ( ) _____Ext.____
Street _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work? ❑ Y ❑ N Work Hours _____

Insurance Information (If no card is available to copy)

Primary Insurer _____ Phone ( ) _____ Group #_____
Street(PO Box) _____ City _____ State ____ Zip _____
Insured's name _____ Insured's ID # _____
Secondary Insurer _____ Phone ( ) _____ Group #_____
Street(PO Box) _____ City _____ State ____ Zip _____
Insured's name _____ Insured's ID # _____

In case of an emergency

Who should be notified? _____ Relationship _____ Phone ( ) _____

Who may we thank for referring you? _____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. _____ _____

Signature Required **Date**

2 Patient Medical History - Overview

What is your foot/ankle problem? _____
_____
_____
When did problem begin? Date: _____
Describe any accident/event: _____
_____
Is this problem work related? ❑ Yes ❑ No
First visit to a Doctor for this problem? ❑ Yes ❑ No
Previous x-rays? ❑ Yes ❑ No If Yes, Date: _____
Where are they now? _____
Describe any previous treatment or home remedies?
_____
_____
_____

Height: _____ Weight: _____ Shoe Size: _____
How much are you on your feet at work?
❑ 20% ❑ 40% ❑ 60% ❑ 80% ❑ 100%
List any sports/activities: _____
_____
Are you taking nutritional or diatary supliments (e.g. Ginkgo biloba, Ginseng, Echinacea)? ❑ Yes ❑ No
List _____

Do you smoke cigarettes? ❑ Yes ❑ No Packs/Day: ___Years: ___
Did you ever smoke? ❑ Yes ❑ No Packs/Day: ___Years: ___
Do you drink alcoholic beverages?
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit
Do you use "recreational" drugs?
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit
List _____
_____

Have you been treated for:

❑ Low back pain	❑ Intoeing	❑ Heel pain
❑ Broken foot bone(s)	❑ Callouses	❑ Rash
❑ Hammertoes	❑ Neuroma	❑ Corns
❑ Ankle injury	❑ Knee pain	❑ Arch pain
❑ High arch feet	❑ Bunions	❑ Flat feet
❑ Ingrown nails	❑ Childhood foot problems	

Do you have or have you ever been treated for:

❑ Diabetes	❑ Anemia	❑ Blood disease
❑ Hepatitis	❑ Phlebitis	❑ Heart trouble
❑ HIV	❑ High Blood Pressure	

Are you slow to heal after cuts? ❑ Yes ❑ No
Any abnormal bruising or bleeding? ❑ Yes ❑ No
Any pain in calves or buttocks when walking? ❑ Yes ❑ No
Is the pain relieved by rest? ❑ Yes ❑ No
Do your feet hurt at night? ❑ Yes ❑ No
Currently taking any prescription medications? ❑ Yes ❑ No
List: _____
_____

Allergies to injection, oral or topical administration of:
Penicillin or other antibiotics? ❑ Yes ❑ No ❑ Don't Know
Narcotics?(Morphine, Codeine, Demerol…) ❑ Yes ❑ No ❑ Don't Know
Local anesthetics? ❑ Yes ❑ No ❑ Don't Know
Pain remedies? ❑ Yes ❑ No ❑ Don't Know
Adhesive tape? ❑ Yes ❑ No ❑ Don't Know
Any other drug, medication or treatment? ❑ Yes ❑ No ❑ Don't Know
If "yes" to any of the above, please explain: _____
_____

Have you had a serious illness? ❑ Yes ❑ No
Have you been hospitalized or under lengthy medical care? ❑ Yes ❑ No
Have you had any surgery? ❑ Yes ❑ No
Do you have any implants? ❑ Yes ❑ No
Orthopedic (e.g. knee, hip, etc.) ❑ Yes ❑ No
Cardiac (e.g. valve, pacemaker, graft, etc.) ❑ Yes ❑ No
Cosmetic (e.g. breast, facial, etc.) ❑ Yes ❑ No
If "yes" to any of the above, please explain: _____
_____
_____

3 Patient Physicians

Did your Family Physician (PCP) or other Specialist refer you? ❑ Yes ❑ No

Family Physician: _____
Date last seen: _____Phone: ( ) _____
City: _____ State: _____ Zip: _____

Are you here for a consultation? ❑ Yes ❑ No
Are you here for a surgical evaluation? ❑ Yes ❑ No

Specialist Dr:_____ Specialty: _____
Date last seen: _____ Phone: ( ) _____
City: _____ State: _____ Zip: _____

Are you here for a 2nd opinion on surgery? ❑ Yes ❑ No
Did you independently come for an opinion? ❑ Yes ❑ No

4 Family History

Has any blood relative had: If "Yes," please indicate who

Tuberculosis?	❑ Yes ❑ No	_____
Cancer or tumor?	❑ Yes ❑ No	_____
High blood pressure?	❑ Yes ❑ No	_____
Heart trouble?	❑ Yes ❑ No	_____
Diabetes?	❑ Yes ❑ No	_____
Birth abnormalities?	❑ Yes ❑ No	_____
Arthritis?	❑ Yes ❑ No	_____
Stroke?	❑ Yes ❑ No	_____
Foot problems?	❑ Yes ❑ No	_____

INSURANCE BENEFITS AND ELIGIBILITY

As a courtesy to our patients we will bill your insurance provider. However, you will be responsible for any non-covered fees, including deductible and co-payments.

Please answer the following questions prior to your first appointment. You may need to contact your insurance provider for verification. Please have your insurance card ready when you call.

Patient name: _____ **ID#:** _____ **Group #:** _____

Insurance provider phone: ( ) _____

Claims billing address: _____

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

Check applicable: ❑ **PPO** ❑ **HMO** ❑ **Private** ❑ **EPO** ❑ **IPA**

Policy effective date: _____

Deductible: _____ **Has deductible been met?** ❑ **Yes** ❑ **No** **Co-pay amount:** _____

Are there financial limits on podiatric care? ❑ **Yes** ❑ **No** **Amount:** _____

Benefit Rate: ❑ **In-Network** _____ ❑ **Out of Network** _____

Is prior authorization required from a primary care physician (PCP)? ❑ **Yes** ❑ **No**

Is your doctor (this appointment) a provider on your plan? ❑ **Yes** ❑ **No**

Are custom orthotic devices a covered benefit? ❑ **Yes** ❑ **No** **% Rate** _____ **Limit** _____

Is a letter of medical necessity required for orthotic devices? ❑ **Yes** ❑ **No**

Name of person contacted at insurance provider: _____

Date of contact: _____

_____ _____

Patient (Guardian) Signature **Date:**