

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____
Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____
E-mail: _____ Spouse/Partner Name: _____
E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Other #: _____
Employer: _____ Phone: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ other
Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____
Address: _____
Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other
Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____
Address: _____
Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend
☐ Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? ☐ Yes ☐ No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other: _____

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: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

- | | | | | | |
|---|--|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues | |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type 1, type 2) | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> other (specify) _____ | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Stroke | | |

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Surgical History

☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long? _____

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

Family History

Is there any family history (blood relative) of: (Please indicate family member)

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

Review of Systems

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

- | | | | | | | |
|-------------------------|--|--|--|--|---|---------------------------------------|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet | |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE | |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE | |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers | <input type="checkbox"/> constipation |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> NONE | |
| Integumentary | <input type="checkbox"/> athlete's foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin | <input type="checkbox"/> NONE |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorders | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches | |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE | |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain | |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring | |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE | |

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: _____

Practice:

Today's Date:

Name: _____		Chart #: _____	Date of birth: _____
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Declined to specify
Race:	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Declined to specify
Preferred Language: _____		<input type="checkbox"/> Declined to specify	
Pharmacy Name: _____		Pharmacy Phone: _____	
Pharmacy Address: _____		City, State, Zip: _____	
Primary Care Physician: _____		Phone: _____	Date Last Seen: _____
Address: _____			
Referring Physician: _____		Phone: _____	Date Last Seen: _____
Address: _____			

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Advanced Directives: ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

PLEASE READ AND SIGN: The information on my intake form(s) 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. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

Name of Patient: _____ Date of Birth: _____

FINANCIAL and APPOINTMENT POLICIES
Advanced Foot Care

Thank you for choosing Advanced Foot Care for your foot care needs. The following policies are being provided to you so that we may prevent any misunderstandings at the time of your visit.

PERSON WHO WILL BE FINANCIALLY RESPONSIBLE FOR THE ACCOUNT (**NOTE:** The parent requesting medical care of a child who is a minor (under the age of 18) will be financially responsible for all charges incurred by the minor child):

NAME: _____ **RELATION TO PATIENT:** _____

ADDRESS: _____

HOME # _____ **CELL #** _____ **WORK #** _____

Our office will file your claim with primary, secondary and tertiary insurance companies. However, please understand that the description of benefits that is provided to us by your insurance company does not guarantee payment of charges. The patient is responsible for any services or supplies not covered under your insurance policy. If you are unsure or unclear about your policy benefits, **please contact your insurance company directly, or refer to your policy manual.** Our office will not become involved in disputes between you and your insurance company regarding coverage and/or benefits.

Payment for copays, deductibles and co-insurance are payable at the time services are rendered, and will be collected prior to treatment. Additional payment may be required at check out if unanticipated treatment was rendered during your visit. Any outstanding balances from a previous visit will also be due prior to treatment. For your convenience, we accept cash, checks, Master Card, Visa, American Express and Discover. If you are unable to make payment, your appointment will need to be rescheduled.

RETURNED CHECKS will be subject to \$25.00 service charge, and must be paid by cash or money order.

HMO PATIENTS **must** obtain a referral from their primary care physician prior to their visit to our office. HMO patients without a valid referral will be unable to be seen by the doctor, or may pay for the visit in full at the time services are rendered.

DISABILITY FORMS: There is a **\$25.00** charge to the patient for completion of non-claim related documents/forms

LATE OR MISSED APPOINTMENTS AND LATE CANCELLATIONS

Late arrivals, missed appointments and late cancellations represent cost to us as well as to other patients who could have been seen in the time that was reserved especially for you. Please call our office 24 hours prior to your visit if you are unable to keep your appointed time. If the required notice is not given, a fee of \$50 will be charged to you. Patients that are over 15 minutes late may need to be rescheduled for another date and time in consideration of our other scheduled patients.

I have read and understand the above statements. I understand that I am financially responsible for all charges and supplies not covered under my insurance policy. I also authorize the release of any information necessary for insurance filing and precertification of treatment.

PATIENT / PARENT / AUTHORIZED REPRESENTATIVE (print)

RELATION TO PATIENT

SIGNATURE, PATIENT / PARENT / AUTHORIZED REPRESENTATIVE

DATE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as states in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.