Forest Med-Surg Podiatry

Today's Date: _____/_____/_____

Name: _____ Date of Birth: ____/____/____
(First) (Mi) (Last)

Social Security Number: _____-_____-_____ Sex: ☐ M ☐ F Marital Status: _____

Preferred Language: _____ Height: _____ Weight: _____ Shoe size: _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Race ☐ Native American/Native Alaskan ☐ Asian ☐ Black/ African American

☐ Native Hawaiian/ Other Pacific Islander ☐ White/ Caucasian ☐ Other: _____

Home Address: _____ City/State: _____ Zip: _____

Home Phone No: (_____) _____-_____ Cell Phone No: (_____) _____-_____

Work Phone No: (_____) _____-_____ E-Mail: _____

Please indicate preferred method of communication ☐ Home/ Cell / Work Phone ☐ Mail ☐ E-Mail

Patient Employer/School: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____-_____

Who is responsible for payment (if other than yourself): _____ Relationship: _____

Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No

If Yes, Name: _____ Relationship: _____ Phone: (____) _____-_____

How were you referred? ☐ INSURANCE ☐ INTERNET ☐ RELATIVE/FRIEND ☐ PATIENT

☐ CLINIC ☐ PHYSICIAN NAME: _____ ☐ OTHER _____

Primary Care Information

Primary Care Physician: _____ Date of last visit: _____

Clinic name: Location: _____

Pharmacy: Location: _____

Social History

Use of Alcohol: ☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ History of alcohol abuse

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke _____ packs/day for _____ years

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily

Family History

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Coronary Artery Disease

☐ Stroke ☐ Rheumatoid Arthritis ☐ Thyroid Disease ☐ Other _____

Medical History

ALLERGIES:

☐ No known allergies ☐ YES, I have the following allergies: _____

Have you been vaccinated this year for: INFLUENZA ☐ Yes ☐ No PNEUMOCOCCAL ☐ Yes ☐ No

Have you ever had any of the following? Check all that apply.

☐ Abnormal Bleeding	☐ Cancer	☐ Kidney Disease	☐ Pneumonia
☐ Acid Reflux	☐ Diabetes	☐ Liver Disease	☐ Polio
☐ AIDS/ HIV Positive	☐ Fibromyalgia	☐ Low Blood Pressure	☐ Rheumatic Fever
☐ Anemia	☐ Glaucoma	☐ Migraine Headaches	☐ Skin Disorder
☐ Arthritis	☐ Gout	☐ Mitral Valve Prolapse	☐ Sleep Apnea
☐ Asthma	☐ Heart Attack	☐ Nerve Disorder	☐ Stomach Ulcers
☐ Back Trouble	☐ Heart Disease/ Failure	☐ Neuropathy	☐ Stroke
☐ Bladder Infections	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid Disease
☐ Blood Clots	☐ High Blood Pressure	☐ Bronchitis/Emphysema	☐ Tuberculosis
☐ Blood Transfusions	☐ Immunosuppressed	☐ Other:_____	

PLEASE LIST ALL SURGERIES: _____

_____

CURRENT MEDICATIONS: *(If you have a list of medications, please present it to front desk for copying)*

Name	For what condition?	Name	For what condition?
_____	_____	_____	_____
_____	_____	_____	_____

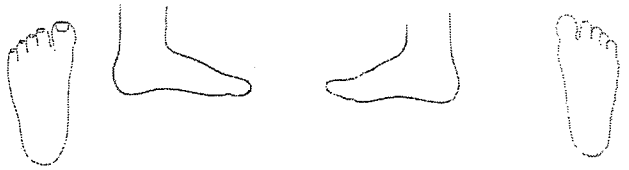
What specific problem brings you to our office today?

_____

Where is the pain/problem located? Please mark on the diagram below.

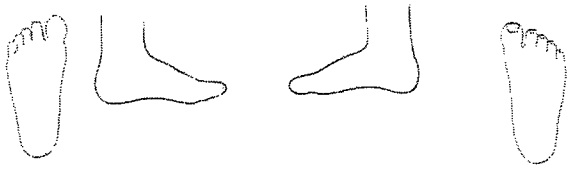
Left foot

Top of foot Inside of foot Inside of foot Top of foot Outside of foot



Right foot

bottom of foot bottom of foot outside of foot



How long ago did this problem start? _____ Work injury? ☐ Yes (describe)_____ ☐ No

How would you rate your pain on a scale from 0 (no pain) to 10 (worst pain possible)? _____

Describe it: ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Shooting Pain ☐ Numbness

PATIENT FINANCIAL POLICY

Your understanding our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff.

As a patient of **Forest Med Podiatry** you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services at **Forest Med Podiatry** _____, is due at the time of service. We accept Visa, MasterCard, Discover, cash or check.

Your health insurance policy(s) is a contract between you and your insurance company(s). As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/co-insurance/deductible at the time of the service.

If you have insurance coverage with a plan we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means the claim may be denied if out-of-network. Therefore, you are responsible for all charges of your care and treatment.

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 "ineligible for coverage" 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 clarifications of benefits prior to services rendered.

You must inform **Forest Med Podiatry** of all insurance changes and authorization/referral requirements. In the event **Forest Med Podiatry** are not informed, you will be responsible for any charges denied.

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.

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 or Parent/Legal Guardian **If other than patient, relationship to patient**

_____ _____

Signature **Date**

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have read and understood the **Notice of Privacy Practices.** I also understand that a copy will be provided to me if I so request.

_____ _____ _____

Print Name of Patient or Parent/Legal Guardian **Signature** **Date**

Forest Med Podiatry Office Policies

We ask that you notify our office **24 hours** in advance if you need to cancel or reschedule your appointment for whatever reason. Failure to cancel in advance or not show for your appointment may results in a **$40 fee** that will be billed or collected at your next appointment.

Patients running **15 minutes** late or more for an appointment may need to be rescheduled. We ask that you call our office to inform us if you are late. We do understand that there may be an unforeseen or emergency reason in which patients may be late or need to cancel an appointment but we ask that out of courtesy to our office and other patients that you inform us as early as possible.

ALL custom products (i.e. - Orthotics, braces, inserts) as well as generic insoles, gel pads and all products that have been opened or used can **NOT** be returned.

We **do not** bill for products sold in office. Please purchase before leaving the office.

It is the patient's responsibility to be informed if the doctor you are seeing is in your network as well as your benefits for Podiatry. Please also be informed of the status of primary and secondary insurances on the initial date of service. We do recommend you call your insurance to verify benefits.

ALL co pays are paid at time of service.

By signing the below line, you are acknowledging that you have read and agree to all of the terms above.

_____ _____

Print Name Signature