Family Foot Care

Name: ________________________________ **Birthdate:** ____-____-____ **Age:** ______
First Last Middle

Who is your primary care doctor/family doctor? ______________________ Today's Date: ____-____-____

Whom may we thank for referring you? ______________________

Sex: M F **Race:** Caucasian African American Hispanic Asian Other: ______________

Email Address: ______________________ (to access patient portal)

Mailing Address

Street: ______________________

City: ______________ State: ____________ Zip Code: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Social Security #: ______________

Employer: ______________ Patient's Occupation: ______________

Employer Mailing Address: ______________________

City: ______________ State: ____________ Zip Code: ____________

If Married, Name of Spouse: ______________ Spouse Date of Birth: ____-____-____

Spouse Employer: ______________ Spouse Phone Number: ____________

In Case of Emergency, contact: ______________ Phone: ____________

Relationship: ______________________

Insurance Information

Must Present Insurance Card

Primary Insurance: ______________________

Who is the Insured? ______________ **Insured Date of Birth:** ____-____-____

Secondary Insurance: ______________________

Who is the Insured? ______________ **Insured Date of Birth:** ____-____-____

I understand that if any of the insurance information I have provided in incorrect or if I fail to notify the office of any insurance changes, I am responsible for all physician charges. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Family Foot Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
I have reviewed this information and is correct to the best of my knowledge.

Patient Signature ______________________ Date ____________

If Minor, Parent Signature:

______________________ Date ____________

Family Foot Care

NAME: ________________________________ Date: ______________

Briefly describe your symptoms/area of pain: ________________________ Date Began: __________

Do you smoke? [ ] Yes [ ] No If yes, how much? ______________________

Do you drink alcohol? [ ] Yes [ ] No If yes, how much? ______________________

Do you take oral contraceptives? [ ] Yes [ ] No **Height:** __________ **Weight:** __________

CHECK ANY THAT APPLY:

AIDS/HIV	[ ] Yes [ ] No	Thyroid problems	[ ] Yes [ ] No	Artificial Heart Valve	[ ] Yes [ ] No
Anemia	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No	History of Gout	[ ] Yes [ ] No
Arthritis	[ ] Yes [ ] No	Heart Disease	[ ] Yes [ ] No	Low blood pressure	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	High Blood Pressure	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No

PREVIOUS SURGERIES OR SURGICAL PROCEDURES: (circle)

FOOT/ANKLE ARM/HAND KNEE HIP BACK LIVER KIDNEY HEAD/NECK CANCER

Other: ____

Are you now or have you been under any other doctor's care during the last year? [ ] Yes [ ] No

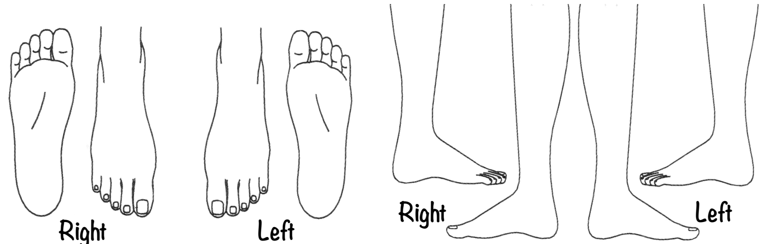
If yes, explain: ____

FAMILY HISTORY:

Condition:	Mother	Father
Diabetes:	[ ] Yes [ ] No	[ ] Yes [ ] No
Heart Disease:	[ ] Yes [ ] No	[ ] Yes [ ] No

Other: ______________________

MARK AREAS OF CONCERN/PAIN:



CURRENT MEDICATIONS: (all prescriptions, vitamins, over-the-counter medications)

____

____

____

Pharmacy Name: ____________________ City: __________ Pharmacy Number: __________

ALLERGIES: Check here if you have NO ALLERGIES [ ]

[ ] Adhesive/Tape/Latex	[ ] Demerol	[ ] Aspirin	[ ] Anticoagulant Therapy
[ ] Codeine	[ ] Penicillin	[ ] Iodine	[ ] Seafood
[ ] Local Anesthetics	[ ] Novocain	[ ] Sulfa	[ ] ____________________

I certify that 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 necessary in the diagnosis and/or treatment of my feet:

Patient (or parent of minor child) Signature:

____ Date ______________

Family Foot Care

Patient Authorization for Contact

Patient Name (please print)**:** ______________________________

initial

Patient Communication Transmittal Consent Form

[ ] Our doctors strive to maintain detailed and accurate medical records of your health care. This goal requires both verbal and written data to be entered into your medical record not only by physicians, but also by office staff, nurses and medical scribes. Verbal communication may be monitored during your visit to enable such detailed and accurate records to be created in a timely manner. All such communication is confidential and protected in order to maintain the privacy of your health information. By your signature below, you agree and consent to such monitoring for recordkeeping purposes. If you do not wish to have such communication monitored, you may opt out of the transmission by informing your physician of such decision.

I, ______________________________, agree and consent to the monitoring of verbal communications between myself and my physician for recordkeeping purposes.

Purpose of Request:
I authorize Family Foot Care to disclose my protected health information in the following manner:

Preferred Telephone: ______________________________
[ ] leave detailed messages on my voicemail
[ ] leave messages with only call-back number (includes staff member name and doctor's office name) on my voicemail

Other Telephone: ______________________________
[ ] leave detailed messages on my voicemail
[ ] leave messages with only call-back number (includes staff member name and doctor's office name) on my voicemail

initial

[ ] Can we call your name in the lobby? [ ] Yes [ ] No

I give my permission to discuss any information from Family Foot Care with the following person/s:

____

Relationship: ______________________________

initial

Notice of Privacy Practices

[ ] I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient: (print name)______________________________ Signature:______________________________

Date:______________________________ Date of Birth:______________________________

If Minor, Parent Signature: ______________________________ Date ____________

Family Foot Care

Financial Policy

All deductibles, co-pays, and co-insurance are due at the time services are rendered.
Payments can be made by check, cash, Visa, MasterCard, or Discover.

If you have medical insurance, a claim will be filed with your insurance. Our office participates in many insurance plans. This means a discounted fee is accepted for many services. The co-pays, deductible, and co-insurance that are deducted from the final allowable fee are the responsibility of the patient or parent if patient is a minor.

These allowable fees with insurance companies can (and will) change often. Many change these “allowable fees” throughout various months of the year, while Medicare usually changes on a calendar year. Since these are somewhat un-predictable, there may be a balance after your insurance pays their amount.

A statement will be sent for any remaining balance. After 90 days any unpaid amounts will have a $20.00 collection fee added and will be forwarded to a collection service. Further interest and fees will be added through assigned collection service accordingly to their policies.

If you have any questionss, please contact our staff.