

Absolute Foot Care Specialists - Podiatric Registration and History Form

DATE: _____

Patient Information:

Patient First Name _____ MI _____ Last Name _____

S.S.# _____ - _____ - _____ Date of Birth _____ / _____ / _____ Age _____ Male Female

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____

Please check the box of the preferred contact phone number

Email Address _____

Occupation _____ Employer _____

Employer Address _____ Phone(_____) _____

Primary Language _____ Marital Status: Single Married Partner Widowed

Spouse/Partner Name _____ Spouse/Partner Date of Birth _____ / _____ / _____

Spouse/Partner S.S.# _____ - _____ - _____

Emergency Contact Name _____ relationship _____ phone _____

For Minors: Names of all parents/guardians _____ phone: _____

Address of parent/guardian; if different _____

Primary Care Physician Information:

Name _____ Phone _____

Address _____ Date last visit _____

Referral Information:

All referrals are appreciated. Who may we thank for referring you to our office?

Name: _____ PCP Specialist Friend Family Member

Health Fair internet insurance plan drive by newspaper Zocdoc.com

Insurance / Payment Information:

Check here if you have NO health insurance

According to my insurance, I am responsible for : Co-pay \$ _____ Deductible Amount \$ _____

Do you need a referral from your PCP? Yes No If yes, do you have a referral? Yes No

Primary Insurance _____ Phone# _____

ID# _____ Group# _____

Policyholder _____ Policyholder Birth date _____ / _____ / _____

Policyholder SS# _____ - _____ - _____ Relationship to patient _____

Secondary Insurance _____ Phone# _____

ID# _____ Group# _____

Policyholder _____ Policyholder Birth date _____ / _____ / _____

Policyholder SS# _____ - _____ - _____ Relationship to patient _____

Tertiary Insurance _____ ID# _____ Policyholder _____

Policyholder Birth date _____ / _____ / _____ Relationship to patient _____

Patient Name: _____ Date: _____ Pg. 2 of 4

Podiatric History and Complaint: What is your COMPLAINT and reason for today's visit? BE SPECIFIC.

What is the ONSET DATE for this issue? _____ Did you receive treatment for this condition? Yes No

List all previous treatments _____

What makes your pain worse? resting after waking standing daily activities walking running
 dress shoes high heels sandals/flip flops worse at night other _____

Check your degree of pain: Minimal 1 2 3 4 5 6 7 8 9 10 Severe

Have you ever experienced any of the following foot/ankle/lower leg conditions in the past year? Check all that apply

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Achilles Tendonitis | <input type="checkbox"/> Chronic Swelling | <input type="checkbox"/> Gout | <input type="checkbox"/> Neuropathy feet | <input type="checkbox"/> Tarsal Tunnel |
| <input type="checkbox"/> Ankle Sprain | <input type="checkbox"/> Corns/Calluses | <input type="checkbox"/> Hammertoe Pain | <input type="checkbox"/> Numbness feet | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetic Foot Pain | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Tingling Feet |
| <input type="checkbox"/> Blisters | <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Ingrown nails | <input type="checkbox"/> PVD/PAD | <input type="checkbox"/> Trauma to feet/legs |
| <input type="checkbox"/> Burning Feet | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Shin Splints | <input type="checkbox"/> Ulcerations feet/legs |
| <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Fracture foot/ankle | <input type="checkbox"/> Nail Fungus | <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Unequal leg length |
| <input type="checkbox"/> Bunion Pain | <input type="checkbox"/> Ganglion Cyst | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Sweaty Feet | <input type="checkbox"/> Plantar Warts |

Is your visit related to: An accident? Yes No An injury? Yes No Workers Compensation? Yes No
If your answer is YES to the above, please describe how, when and where the accident/injury occurred:

Worker's Comp: Was a C-4 form filled out? Yes No Are you represented by a lawyer? Yes No

Medical History: Have you ever had for any of the following conditions?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis(area) _____ | <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cancer (of) _____ | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV+ | <input type="checkbox"/> PAD | <input type="checkbox"/> Ulcerations feet/legs |
| <input type="checkbox"/> DVT/Embolism | <input type="checkbox"/> Hypertension | <input type="checkbox"/> PVD | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Phlebitis leg | |
| <input type="checkbox"/> Fatigue (chronic) | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Psychiatric Disorder | |

Other medical issues: _____

Are you currently Pregnant? Yes No Are you currently Nursing? Yes No

Diabetes: Are you Diabetic? Yes No Type 1 _____ Type 2 _____ Last HbA1c _____ % Blood sugar well controlled? Yes No Average daily blood sugar _____

Do you experience? Calf / leg pain: with resting? Yes No with walking? Yes No Leg cramping? Yes No

What is your: Height? _____ feet _____ inches Weight? _____ Shoe Size? _____

Social History:

- 1) Do you smoke cigarettes? Yes No If yes, for how long? _____ How many per day? _____
 2) Quit smoking? N/A Yes No When? _____ years months weeks
 3) Do you use Alcohol? Yes No Quantity? _____ per: day week month year
 4) Recreational Drug use? Yes No Type: Marijuana Crack/Cocaine Heroin Methamphetamines
 Other: _____ Frequency: _____ Last used? _____ History of Chemical Dependency? Yes No

5) Level of activity: inactive sedentary moderate vigorous extreme

6) Activities/Hobbies/Sports played: _____

Patient Name: _____

Date: _____

Review of Systems: Please check any conditions you are currently experiencing (within the past year):

General:

- good general health
- chronic fatigue
- dizziness
- night sweats/chills
- weight gain >10lbs
- weight loss >10lbs

Endocrine:

- Diabetes
- excessive thirst
- excessive sweating
- hair loss
- hot/cold intolerance
- hypothyroid

Skin:

- Athlete's foot
- change in skin color
- dry skin feet/legs
- itching skin feet/legs
- ulcerations feet/legs
- rash(area) _____

Musculoskeletal:

- ankle pain
- arthritis _____
- back pain
- foot pain
- heel pain
- hip/knee pain
- joint pain/stiffness
- joint swelling

Cardiovascular:

- cold feet
- blood clots/DVT
- chest pain
- hypertension
- hyperlipidemia
- leg cramping
- leg/foot swelling
- palpations
- Peripheral vascular disease
- Stroke (CVA)

Neurologic:

- burning feet
- tingling feet
- numbness feet
- peripheral neuropathy
- Fibromyalgia
- Multiple Sclerosis
- Parkinson's Disease
- paralysis
- seizure disorder
- tremors

Infectious Disease:

- Hepatitis type _____
- Herpes Virus
- HIV+ / AIDS
- MRSA
- recurrent skin infections
- tuberculosis

Psychiatric:

- anxiety
- depression
- psychiatric disorder

Lymphatic/Hematologic

- anemia
- easily bruise
- swollen extremities
- swollen lymph node

Respiratory:

- asthma
- COPD
- sleep apnea

GU:

- kidney disease

HEENT:

- cataracts
- difficulty swallowing
- hearing loss
- glaucoma
- ringing in ears

Rheumatologic

- gout
- Lupus
- rheumatoid arthritis
- scleroderma

Gastrointestinal:

- acid reflux/GERD
- nausea
- vomiting

Please list any other current medical condition: _____

Medication Record: (please use an additional sheet of paper if needed for medications)

NO MEDICATION TAKEN

Name of medication / dosage / taken how often?

Name of medication / dosage / taken how often?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

Allergies to Medication: (be very specific on the reaction the drug caused)

NO ALLERGIES (NKDA)

Drug Name / Side Effect

Drug Name / Side Effect

- 1) _____
- 2) _____
- 3) _____
- 4) _____

- 5) _____
- 6) _____
- 7) _____
- 8) _____

Surgeries: Please list all surgery you have had; specify, "left" or "right", with the date:

NO SURGERIES

Do you have any type of: metal implants pacemaker defibrillator plates/screws/rods shrapnel
Location of each? _____

Signature/Consent/Permission for Treatment / Assignment and Release / Receipt of Privacy Practices

I understand that the information provided on all the forms in the Podiatric Registration packet are true and correct to the best of my knowledge. I acknowledge that I have received notice of Privacy Practices and my rights as a patient. I give permission to the doctor to administer and perform any such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet, ankles and/or lower legs. I, the undersigned, have valid insurance coverage with the insurance companies listed on page one, and assign directly to the doctors of Absolute Foot Care Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I recognize that I am financially obligated for any coinsurance, co-pays, deductibles and/or non-covered/denied services that may be required. I understand that I am financially responsible for all charges whether or not paid by my insurance, and I am responsible for all charges made to my account whether or not an insurance company, attorney or third party payor is involved in payment. I agree to pay all collection expenses including attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency ranging from 40-50% retained to pursue collection of monies owed by me for services rendered by Absolute Foot Care. I hereby authorize Absolute Foot Care Specialists to release any information necessary to secure the payment of benefits. A photocopy of this authorization is to be considered as a valid as the original until it is revoked by me in writing. I authorize the use of the signature below on this page, on all insurance submissions.

Financial Policy of Absolute Foot Care Specialists

- 1) **Insurance.** We participate with most health insurance plans, including Medicare and will bill them on your behalf. Knowledge of your insurance coverage, co-pay, coinsurance and deductible is the **patient's responsibility**. Please contact your insurance company with questions you have regarding your coverage. If you do not have insurance, payment is expected in full at the time of service.
- 2) **Co-payments/Co-insurance/Deductible.** All co-pays, coinsurance and deductibles are expected to be paid at the time of service, unless prior arrangements are made with the office. This is part of your contract with your insurance company.
- 3) **Non-Covered services.** Please be aware that some services that you receive may not be covered by your insurance. By signing below, you acknowledge that you are financially responsible for the services, even if your insurance denies or deems the services as non-covered or not medically necessary.
- 4) **Proof of Insurance.** All patients/guardians must complete the patient information form and provide a copy of a valid insurance card and picture identification (or responsible party's picture identification) before being seen by the doctor. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of your claim(s). If required, obtaining the proper referral form from your Primary Care Physician is your responsibility. Patients without a valid referral will be asked to pay in full at the time of service.
- 5) **Claims Submission.** On your behalf, we will submit your claim(s) and assist you in any reasonable way to help get your claim(s) paid. We will submit claims to your secondary insurance one time, if applicable. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance coverage is a contract between you and your insurance company.
- 6) **Patient Responsibility with Insurance.** Your insurance company may request you to supply certain information directly to them in order to process your claim(s). It is your responsibility to comply with their request in a timely manner, or per your insurance contract, they will hold you financially responsible to pay the claim(s) without contractual adjustments.
- 6) **Patient Information Changes.** If your insurance, address, name or phone changes, you are responsible for notifying this immediately, so we may make the appropriate changes to have your insurance claims processed in a timely manner by your insurance. If we are not notified in a timely manner, you may be held responsible for the balance of the claim(s).
- 7) **Nonpayment and Collection policy.** (3) Invoices will be sent for your bill, on a monthly basis. If your account is over 90 days past due and no prior payment arrangement has been made, your account will be turned over to a collection agency for non-payment. You will be responsible for your charges plus a 40% collection fee and any legal fees incurred in the process of collections. Any bounced checks will carry a bounced check fee of \$35.00. By signing below you acknowledge that you accept the terms of our collection policy and all associated fees.
- 8) **Re-billing Fee:** I agree to pay a fee of \$15 for every additional billing statement sent to me, after first statement, for which there will be no charge. This will be in effect, unless there is a prior payment arrangement made with Absolute Foot Care Specialists billing department.
- 9) **Missed appointments.** Our policy is that all patients will be charged a fee of \$35.00 for any missed appointment that is not cancelled 24 hours in advance. If you cancel an appointment on the day of that appointment, you will still be charged this fee. For Special Testing appointments, a fee of \$75.00 will be charged for not cancelling 72 hours in advance. Patients having special testing will be asked to sign an acknowledgement form in advance. Please help us to serve you better by keeping your scheduled appointments.
- 10) **FMLA / Disability Paperwork.** Any paperwork, including but not limited to FMLA and disability, will carry a fee of \$10.00 per page and will be processed within 15 business days. Payment for this service is due in advance.

SIGNATURE REQUIRED (Please read carefully. Sign and Date below). This entire form will be VOID if modified by the patient. Any patient who does not sign this form as is, will not be seen for treatment. By signing below I acknowledge that I agree to and will comply with all points on this form.

Patient/Responsible Party Signature _____

Date _____

Print Name _____

Relationship to Patient _____