The Foot Health Center

PATIENT INFORMATION

All information given is Confidential. Please fill out completely and sign below

First Name _____ MI_____ Last Name _____

SSN # _____ Birth Date _____Age _____

SEX: ❑ Male ❑ Female Name you go by_____

Address _____

City_____State_____Zip _____

Home Phone _____ Work _____Cell_____

Email Address _____

MARITAL STATUS: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer Name _____ Occupation_____Phone_____

Physician's Name _____ City_____Phone _____

PHARMACY

Name_____ Address_____ Phone _____

Medications _____

SPOUSE INFORMATION (OR PARENT IF MINOR)

Spouse /Parent Name _____

Employer_____Phone _____

If Minor - RESPONSIBLE PARTY

Who is responsible for this account? _____ Relationship to Patient _____

Address _____ Phone # _____

Date of Birth _____ Social Security # _____

Employer _____ Occupation _____

Employer Address _____ Phone # _____

How did you hear about our facility? ❑ Internet (Website / Facebook / Search Engine) Circle One
❑ Family /Friend_____ ❑ Doctor Referral ❑ Sign
❑ Billboard ❑ TV / Radio ❑ Previous Patient

CHIEF COMPLAINT TODAY _____

ACCIDENT OR INJURY INFORMATION

Date of Accident or Injury _____

Where the accident or injury took place _____

How Accident or Injury occurred _____

All information given above is true and correct to the best of my knowledge.

Signature of Patient or Legal Guardian_____ **Date** _____

INSURANCE INFORMATION

Note: Please Present your Insurance Card to Receptionist

PRIMARY INSURANCE

Insurance Name _____

Member ID # on Insurance Card _____

Group Number _____ Group Name _____

Policy Holder's Name _____

Policy Holder's Birth Date _____ SSN# _____

Relationship to Patient: ❑ Self ❑ Child ❑ Spouse

SECONDARY INSURANCE

Insurance Name _____

Member ID # on Insurance Card _____

Group Number _____ Group Name _____

Policy Holder's Name _____

Policy Holder's Birth date _____ SSN # _____

Relationship to Patient: ❑ Self ❑ Child ❑ Spouse

HMO Patients

YOU ARE RESPONSIBLE FOR YOUR OWN REFERRAL AND AUTHORIZATIONS.

Please make sure you know how many visits you have and how long they are good for. Most referrals are only good for 60 or 90 days. Please ask the receptionist before leaving or call the office to make sure your referral has not expired. If you do not have proper authorization to see the doctor, you, the patient, will be solely responsible for the cost of the visit.

All Patients

I, hereby authorize, The Foot Health Center, to release any medical records or information necessary to process this claim and any future claims that I may have. I also authorize payment of medical benefits directly to the physician and or provider as long as I am a patient. If it is necessary to involve a third party collector or an attorney for payment of services, I will be responsible for all cost of collection in the event of default. **I understand that I, the patient, have a contract with my insurance company, not the doctor, and if for some unforeseen reason there is a dispute with my claim, I, the patient, will be responsible for the cost of services given to me by The Foot Health Center.**

Signature _____ **Date** _____

PODIATRIC HISTORY

ALLERGIES:

❑ Adhesive Tape ❑ Aspirin ❑ Betadine ❑ Codeine ❑ Demerol ❑ Erythromycin

❑ Iodine ❑ Penicillin ❑ Quinolones ❑ Sulfa ❑ Local Anesthetics ❑ NONE

❑ Other_____

CURRENT MEDICATIONS:

Please list all medicines which you now use:

_____

_____

VITALS:

Current Weight_____ Current Height _____ What is your shoe size? _____

ACTIVITIES *(please list any activities that you participate in)*

_____

EXERCISE

_____

SOCIAL HISTORY

Do You Drink Alcohol? ❑ YES ❑ NO

Do You Smoke? ❑ CURRENT ❑ FORMER ❑ NON-SMOKER

Recreational Drug Use ❑ YES ❑ NO

OCCUPATION:_____

❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled ❑ Full Time ❑ Part Time

Name of Company_____

FAMILY HISTORY

Is there a Family History of any of these disorders?

❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Gout ❑ Heart Trouble

❑ High Blood Pressure ❑ Kidney ❑ Mental ❑ Migraines ❑ Stroke

Continued on next page

REVIEW OF SYMPTOMS

Please indicate if you have any of the following:

General:	❑ Change in Appetite ❑ Fever	❑ Chills ❑ Night Sweats	❑ Fatigue ❑ Weakness
Cardiac:	❑ Chest pain ❑ Heart Attack	❑ Feet Swell ❑ Heart Murmur	❑ Hands Swell ❑ Leg Pain
Endocrine:	❑ Diabetic Type I	❑ Diabetic Type II	❑ Thyroid Problems
GI:	❑ Abdominal Pain ❑ Liver Trouble	❑ Gallbladder ❑ Nausea	❑ Indigestion ❑ Stomach Trouble
Genitourinary:	❑ Bladder Trouble ❑ Kidney Stones	❑ Frequent Urination ❑ Prostate Trouble	❑ Kidney Disease
Hematologic/Lymphatic:	❑ Anemia	❑ Excessive Bleeding	❑ Aspirin Use
Musculoskeletal:	❑ Arthritis ❑ Fractures ❑ Sprains	❑ Back Pain ❑ Joint Pain ❑ Stiffness	❑ Bone Pain ❑ Muscle Pain
Neurologic:	❑ Dizziness ❑ Paralysis	❑ Headache ❑ Seizures	❑ Numbness /Tingling
Peripheral Vascular:	❑ Blood Clots	❑ Cramps	❑ Poor Circulation ❑ Varicose Veins
Psychiatric:	❑ Depression	❑ Other_____	
Respiratory:	❑ Asthma ❑ Sinus Problems	❑ Lung Problems ❑ TB Exposure	❑ Shortness of Breath
Rheumatology:	❑ Fibromyalgia		
Skin:	❑ Bruising ❑ Itching ❑ Skin Ulcerations	❑ Deformed Nails ❑ Rashes	❑ Discoloration of Nails ❑ Scarring Tendencies
Other:	❑ Hearing Loss	❑ Vision Loss	❑ Fibromyalgia

❑ None of the above pertains to me.

MEDICAL HISTORY

Please indicate below what you have been diagnosed with by another Physician
This page is not a duplicate

Please list any previous Surgeries:_____

_____

Cardiovascular:	❑ Angina	❑ High Blood Pressure	❑ Mitral Valve Prolapse	
	❑ Murmur	❑ Stroke		
Endocrine:	❑ Diabetes	* Date you were diagnosed _____		
		* Name of your doctor treating you for Diabetes _____		
		* Date you last saw your Doctor _____		
		Your last A1C Level _____		
	❑ Hyperthyroid	❑ Hypothyroid	❑ Osteoporosis	
Gastrointestinal:	❑ Cirrhosis	❑ Gallbladder	❑ Gastritis	
Genitourinary:	❑ Prostate	❑ Renal Failure		
HEENT:	❑ Cataracts	❑ Dizziness	❑ Macular Degeneration	❑ Sinusitis
Hematology:	❑ Deep Vein Thrombosis		❑ Coagulation Disorders	
Infectious Disease:	❑ AIDS	❑ Abscess	❑ Hepatitis	❑ Osteomyelitis
Malignancy:	❑ Bladder Cancer	❑ Breast Cancer	❑ Gallbladder Cancer	❑ Leukemia
	❑ Liver Cancer	❑ Lung Cancer	❑ Thyroid Cancer	
Musculoskeletal:	❑ Back Pain	❑ Charcot Joint	❑ Reflex Sympathetic Dystrophy	
	❑ Sprain			
Neurology:	❑ Alzheimer's	❑ Cerebral Palsy	❑ Headache	❑ Parkinson's Disease
	❑ Seizures	❑ Stroke		
Psychiatry:	❑ Anxiety	❑ Bipolar	❑ Depression	
Respiratory:	❑ Asthma	❑ COPD	❑ Emphysema	
Rheumatology:	❑ Fibromyalgia	❑ Gout	❑ Rheumatoid Arthritis	
Skin:	❑ Psoriasis	❑ Eczema	❑ Lipoma	

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition(s).

_____ _____

(Patient Signature) Date

The Foot **Health Center**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____

Print Name of Patient

_____ _____

Signature of Patient, Parent or Authorized Representative Date

The Foot Health Center

FINANCIAL POLICY

Thank you for choosing The Foot Health Center as your healthcare provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing dept at 618.344.4449.
Your clear understanding of our Financial Policy is important to our professional relationship.

WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD.

IF YOU DO NOT HAVE YOUR INSURANCE CARD WITH YOU, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, OR CREDIT/DEBIT CARD.

ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.

PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.

SELF PAY Patients

We expect payment at the time of service unless prior arrangements have been made.

MEDICARE Patients

We accept Medicare assignment. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare. We will advise you of any non-covered charge prior to the service being provided.

HMO/PPO Patients

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. We are members of most, but not all plans; you are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

WORKERS' COMPENSATION

If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resource office should be able to assist you with obtaining this information). If payment is not received from the third party within 90 days, we have the right to bill you directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at The Foot & Ankle Center may have a financial interest in a surgery center where you will be having your surgery.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit proper information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services. If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.

I will pay unpaid balance by: _____Cash _____Check _____Credit Card

_____	_____	_____
Name of Patient (please print)	**Signature of Patient or Responsible Party**	**Date**