Absolute Foot Care Specialists - Podiatric Registration and History Form

DATE:_____

Patient Information:

Patient First Name_____ MI_____ Last Name_____

S.S.#_____-_____-_____ Date of Birth_____/_____/_____ Age_____ Sex_____ Gender_____

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 _____

Pharmacy Name:_____ Address:_____Phone:_____

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 search ❒insurance plan ❒drive by ❒Hospital_____ ❒Other_____

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_____

Podiatric History and Complaint: What is your **COMPLAINT** and reason for todays 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? ❒rest ❒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

❒Achilles Tendonitis	❒Chronic Swelling	❒Gout	❒Neuropathy feet	❒Tarsal Tunnel
❒Ankle Sprain	❒Corns/Calluses	❒Hammertoe Pain	❒Numbness feet	❒Tendonitis
❒Arthritis_____	❒Diabetic Foot Pain	❒Heel Pain	❒Plantar Fasciitis	❒Tingling Feet
❒Blisters	❒Flat Feet	❒Ingrown nails	❒PVD/PAD	❒Trauma to feet/legs
❒Burning Feet	❒Fungal Infection	❒Joint Pain	❒Shin Splints	❒Ulcerations feet/legs
❒Bone Spurs	❒Fracture foot/ankle	❒Nail Fungus	❒Skin discoloration	❒Unequal leg length
❒Bunion Pain	❒Ganglion Cyst	❒Neuroma	❒Sweaty Feet	❒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?

❒Anemia	❒Fibromyalgia	❒Kidney Disease	❒Respiratory Disease
❒Arthritis(area)_____	❒GERD/reflux	❒Liver Disease	❒Restless Leg Syndrome
❒Asthma	❒Heart Attack	❒Multiple Sclerosis	❒Sleep Apnea
❒Bleeding Disorder	❒Heart Disease	❒Nervous Disorder (anxiety)	❒Stomach Ulcers
❒Cancer (of)_____	❒Hepatitis Type____	❒Neurological Disorder	❒Stroke (CVA)
❒Diabetes	❒High Cholesterol	❒Parkinson's	❒Tuberculosis
❒Depression	❒HIV+	❒PAD	❒Ulcerations feet/legs
❒DVT/Embolism	❒Hypertension	❒PVD	❒Varicose Veins
❒Epilepsy	❒Hypotension	❒Phlebitis leg	
❒Fatigue (chronic)	❒Hypothyroid	❒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 _____%
Are your 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 ❒Heroine ❒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:_____

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

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

Lymphatic/Hematologic
❒anemia
❒easily bruise
❒swollen extremities
❒swollen lymph node

Endocrine:
❒Diabetes
❒excessive thirst
❒excessive sweating
❒hair loss
❒hot/cold intolerance
❒hypothyroid

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

Respiratory:
❒asthma
❒COPD
❒sleep apnea

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

Infectious Disease:
❒Hepatitis type_____
❒Herpes Virus
❒HIV+ / AIDS
❒MRSA
❒recurrent skin infections
❒tuberculosis

GU:
❒kidney disease

HEENT:
❒cataracts
❒difficulty swallowing
❒hearing loss
❒glaucoma
❒ringing in ears

Musculoskeletal:
❒ankle pain
❒arthritis_____
❒back pain
❒foot pain
❒heel pain
❒hip/knee pain
❒joint pain/stiffness
❒joint swelling

Psychiatric:
❒anxiety
❒depression
❒psychiatric disorder

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?

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

Name of medication / dosage / taken how often?

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

Allergies to Medication: **(be very specific on the reaction the drug caused)** **❒NO ALLERGIES (NKDA)**

Drug Name / Side Effect

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

Drug Name / Side Effect

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

Surgeries: Please list all surgery you have had; specify**, "left" or "right" if applicable, 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 herby 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 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. I agree to pay all fees at time of service.

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. I agree that I will be financially responsible for any and all services not covered by my insurance.

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).

5) Referrals: If required by your insurance, 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. I acknowledge I will be responsible for the bill if a referral is not received.

6) 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. I am aware that the balance of my claim is my responsibility whether or not your insurance company pays your claim.

7) 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, per your insurance contract, if you do not you will be held financially responsible to pay the claim(s) without contractual adjustments.

8) Patient Information Changes. If your insurance, address, name or phone changes, you are responsible for notifying Absolute Foot Care of 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).

9) 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. I acknowledge and agree that in the event I do not pay for services rendered, Absolute Foot Care may place my account with a collection agency. The patient or responsible party agrees to pay any collection fees, court costs and/or attorney's fees, that may be incurred to satisfy their obligation. Any bounced checks will carry a bounced check fee of $35.00. By signing below I acknowledge that you accept the terms of our collection policy and all associated fees.

10) Missed appointments. I acknowledge that I will be charged a fee of $35.00 for any missed appointment that is not cancelled 24 hours in advance. If I cancel an appointment on the day of that appointment, I acknowledge I will still be charged this fee.

11) 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_____

Absolute Foot Care Specialists
Prescription Drug Patient Agreement

The law requires responsible usage of prescription drugs by patients. If you accept a prescription from Dr. Noah Levine, you are accepting responsibility to use the medication as directed. By signing below, you agree to follow these rules:

1. Refill requests will be made during normal business hours and subject to discretion of Dr. Levine. I understand I may need monthly appointments for refills. Narcotics will not be refilled after hours, on weekends, or holidays. **It is my responsibility to ensure I have enough medication to last through weekends, holidays, or after clinic hours.**
2. Only one pharmacy will be used for filling prescriptions. If my pharmacy changes, I will inform my doctor immediately.
3. As the patient, I am responsible for my controlled medication (narcotics, muscle relaxants, sleep aids). I will keep the medications safely in my care. I will not tell friends or family members there are prescription pain medications in the house. I will not share this medication with anyone.
4. I understand some medications, like narcotics, may have side effects which can be dangerous, such as sleepiness, sedation, constipation, nausea, itching, allergic reactions, problems thinking clearly, slowing of reaction time and slowing of breathing. When I take narcotic medication, I will not drive a car, operate machinery or take care of other people. I will not do anything to put other people at risk of being injured.
5. I agree to receive these medications only from Dr. Noah Levine.
6. I will not consume alcohol in excess while taking prescribed narcotic pain medication.
7. I will not use, purchase, or obtain illegal drugs while taking narcotic pain medication.
8. I will disclose to Dr. Noah Levine all prescription medications, including medicinal marijuana.
9. I agree that if I obtain prescriptions for narcotic pain medications from a source other than Dr. Noah Levine, this agreement will be void and prescriptions for pain medication will be discontinued.
10. I will allow Dr. Noah Levine and his staff to contact pharmacists and other medical professionals involved in my care to discuss my medications.
11. I will take all medications exactly as instructed and prescribed. Any unauthorized increase in dose will be viewed as a cause for stopping treatment.
12. I agree to keep regular follow up appointments as recommended by my physician.
13. I am aware that if I choose to drive while taking these medications I may be charged with driving under the influence (DUI).
14. I understand that narcotics are prescribed for **a maximum of 30 days following surgery**. If I require narcotic pain medication beyond 30 days, I may need to establish care with a Pain Management physician.
15. If my medications are lost, misplaced, destroyed, unintentionally used or stolen, prescriptions will NOT be replaced. Early prescription renewals are prohibited.
16. I understand that narcotic pain medication can be addictive and I may become dependent on them with regular use.
17. FOR WOMEN: It is my responsibility to advise my doctor if I think I am pregnant or may become pregnant. Prescription medication may cause harm to a fetus in utero.
18. I understand, that if I violate this agreement, I am subject to having any further prescriptions for controlled medication terminated.

Print Patient Name:_____

Patient or Guardian Signature: _____

Date: _____