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_____

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? ❒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

❒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	❒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 _____% 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", 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. Per NRS 649.375(2)(b), a collection fee of 50% will be added to the balance in the event the terms are not met and reasonable attorney fees and court costs incurred in collection of my past due account. 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_____