



## New Patient Paperwork

<b>Today's Date:</b> _____ / _____ / _____				
<b>Patient Name:</b>	<i>Last</i> _____	<i>First</i> _____	<i>MI</i> _____	<i>Date of Birth</i> _____
				<b>Sex (Circle):</b> M F
<i>Home Address:</i> _____			<i>City/State</i> _____	
<i>Home Phone #</i> _____		<i>Work Phone #</i> _____		<i>Cell Phone #</i> _____
<i>Email Address (Mandatory)</i> _____				<i>Primary Language</i> _____
<i>Race</i> _____			<i>Ethnicity</i> _____	
<b>Do you have a legal guardian or healthcare power of attorney?</b> YES      NO				
<i>If yes, Name:</i> _____		<i>Relationship</i> _____		<i>Phone #</i> _____
<i>Emergency Contact:</i> _____		<i>Relationship:</i> _____		<i>Phone Number:</i> _____
<i>Primary Care Doctor:</i> _____				<i>Phone:</i> _____
<i>Date of Last Primary Care Appointment:</i> _____				
<i>Primary Insurance Company Name</i> _____				<i>Policy Number</i> _____
<i>Preferred Pharmacy</i> _____				<i>Pharmacy Phone Number</i> _____
<b>How did you hear about us?</b> <input type="checkbox"/> Insurance Company Website <input type="checkbox"/> Referral <input type="checkbox"/> Google <input type="checkbox"/> ZocDoc <input type="checkbox"/> Friend <input type="checkbox"/> Online ad <input type="checkbox"/> Medical Lecture <input type="checkbox"/> Postcard <input type="checkbox"/> Other: _____				
<b>Current Problem</b>				
<b>What is the reason for your visit today?</b> _____				
<b>How long ago did this problem start?</b> _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years				
<b>Did the pain or problem:</b> <input type="checkbox"/> Begin all of a sudden <input type="checkbox"/> Gradually develop over time				
<b>How would you describe the pain?</b> <input type="checkbox"/> No pain <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Radiating <input type="checkbox"/> Itching <input type="checkbox"/> Stabbing <input type="checkbox"/> Other _____				
<b>How would you rate the pain on a scale from 0 to 10? (Please Circle)</b> (no pain) 0    1    2    3    4    5    6    7    8    9    10 (worse pain possible)				
<b>Since the pain began, has it:</b> <input type="checkbox"/> stayed the same <input type="checkbox"/> become worse <input type="checkbox"/> improved				
<b>What makes your pain or problem worse?</b> <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Daily Activities <input type="checkbox"/> Resting <input type="checkbox"/> Dress shoes <input type="checkbox"/> High Heels <input type="checkbox"/> Flat Shoes <input type="checkbox"/> Closed Toe Shoes <input type="checkbox"/> Running <input type="checkbox"/> Other: _____				



**What makes the pain or problem feel better?**

**What treatments have you had for this problem?**

**What treatments have you tried for this problem?**

**Was this problem caused by an injury?**  YES (describe) \_\_\_\_\_  NO

**If so, was this injury work-related?**  YES  NO

**Medical History**

**Do you have any of the following medical problems?**  Anemia  Anxiety  Back pain  Bleeding problems  
 Blood clots  Cancer: type \_\_\_\_\_  COPD  Depression  Diabetes: type \_\_\_\_\_ last  
hemoglobin A1c % \_\_\_\_\_  Fibromyalgia  Gout  Heartburn/Reflex  Heart Failure  Heart Problems  
 Heart Attacks  HIV/AIDS  High Blood Pressure  Joint Implants  Kidney Problems  Liver Problems  
 Migraines  Neuropathy  Open Sores  Osteoporosis  Peripheral vascular disease  Polio  
 Rheumatoid Arthritis  Sickle Cell Disease  Skin Problems  Sleep Apnea  Stomach Ulcers  Stroke  
 Thyroid Disease  Tuberculosis

**Other Medical Problems Not Listed Above:**

**Surgical History – Please List All Prior Surgeries and the Date of The Surgeries**

1.	4.
2.	5.
3.	6.

**Family History – List Any Relatives With the Following Medical Problems:**

Diabetes _____	Stroke _____
Cancer _____	Thyroid Disease _____
Heart Disease _____	Rheumatoid Arthritis _____
High Blood Pressure _____	Other: _____

**Social History**

**Marital Status:**  Single  Married  Partnered  Separated  Divorced  Widowed

**Alcohol Use:**  Never  No Longer Use  Rare  Occasional  Moderate  Daily

**Tobacco Use:**  Never  Quit – How long ago? \_\_\_\_\_  Smoke \_\_\_\_\_ Packs/Day for \_\_\_\_\_ Years

**Recreational Drugs:**

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**How much are you on your feet at work?**  10%  25%  50%  75%  100%

**How much do you exercise?**  Never  Rarely  Weekly  Several Times Per Week  Daily

**Hospitalizations – Please List All Hospitalizations Within the Past 5 Years**

1.	4.
2.	5.

**Allergies: Please List All Of Your Allergies Below:**

**Medication Allergies:** \_\_\_\_\_ **Other Allergies:** \_\_\_\_\_

**Medications – Please List All Medications You Are Currently Taking (Including prescriptions, over-the-counter and herbal supplements)**

<b>Medication</b>	<b>Dose</b>	<b>How Often Do You Take?</b>	<b>Medication</b>	<b>Dose</b>	<b>How Often Do You Take?</b>



Review of Systems
For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, <b>PLEASE CIRCLE THE ONES THAT APPLY</b> , or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.
<b>Const. (Health in General)</b> <input type="checkbox"/> No Problems, Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:
<b>Ears, Nose, Mouth &amp; Throat</b> <input type="checkbox"/> No Problems, Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:
<b>C-V (Heart &amp; Blood Vessels)</b> <input type="checkbox"/> No Problems, Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:
<b>Resp. (Lungs &amp; Breathing)</b> <input type="checkbox"/> No Problems, Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:
<b>GI (Stomach &amp; Intestines)</b> <input type="checkbox"/> No Problems, Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:
<b>GU (Kidney &amp; Bladder)</b> <input type="checkbox"/> No Problems, Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other:
<b>MS (Muscles, Bones, Joints)</b> <input type="checkbox"/> No Problems, Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:
<b>Integ. (Skin, Hair &amp; Breast)</b> <input type="checkbox"/> No Problems, Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:
<b>Neurologic (Brain &amp; Nerves)</b> <input type="checkbox"/> No Problems, Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:
<b>Psychiatric (Mood &amp; Thinking)</b> <input type="checkbox"/> No Problems, Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:
<b>Endocrinologic (Glands)</b> <input type="checkbox"/> No Problems, Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:
<b>Hematologic (Blood/Lymph)</b> <input type="checkbox"/> No Problems, Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:
<b>Allergic/Immunologic</b> <input type="checkbox"/> No Problems, Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:
<b>Peripheral Vascular Disease</b> <input type="checkbox"/> No Problems, Intermittent claudication, leg cramps, varicose veins

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.		
<b>Patient Name (Print here)</b>	<b>Signature</b>	<b>Date</b>
<i>Physician Signature</i>		<i>Date</i>

Over 70% of our patients bring in their children. Children have various foot problems including plantar warts and flat feet. Did you know that most foot problems are genetic? It is always good to have your child looked at. An ounce of prevention is worth a pound of cure.



<b>Patient</b> <i>First Name</i> <i>Last Name</i>			<b>Date of Birth</b> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 33%; padding: 2px;">Month</td> <td style="width: 33%; padding: 2px;">Day</td> <td style="width: 33%; padding: 2px;">Year</td> </tr> </table>			Month	Day	Year
Month	Day	Year						
<i>Street Address</i>			Legal Guardian Name if different from patient					
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<i>City</i>	<i>State</i>	<i>Zip</i>						
<b>AUTHORIZATION FOR TREATMENT &amp; RELEASE OF INFORMATION</b>			<b>SUMMARY OF NOTICE OF PRIVACY PRACTICES</b>					
<p>I, the patient, legal guardian or health care surrogate, hereby authorize Precision Foot and Ankle, P.A. doctors and staff to examine and treat the aforementioned, if necessary. I understand that this consent may be withdrawn at any time and withdrawal of consent must be in writing to the Precision Foot and Ankle, P.A. doctors and staff. I understand that photographs may be taken by Precision Foot and Ankle PA doctors and staff for documentation purposes to be included as part of the medical record.</p> <p>The patient, legal guardian or health care surrogate authorizes Precision Foot and Ankle PA doctors and staff to disclose appropriate and necessary clinical information to other facility staff for the purpose of treatment. Clinical information can be released to family members listed below for purposes of treatment:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50px; height: 30px; vertical-align: top;">1.</td> </tr> <tr> <td style="width: 50px; height: 30px; vertical-align: top;">2.</td> </tr> <tr> <td style="width: 50px; height: 30px; vertical-align: top;">3.</td> </tr> </table>			1.	2.	3.	<p><b>Uses and Disclosures of Health Information</b> We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.</p> <p><b>Uses and Disclosures Based on Your Authorization</b> Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.</p> <p><b>Uses and Disclosures Not Requiring Your Authorization</b> In the following circumstances, we may disclose your health information without your written authorization:</p> <ul style="list-style-type: none"> <li>• To family members or close friends who are involved in your health care;</li> <li>• For certain limited research purposes;</li> <li>• For purposes of public health and safety;</li> <li>• To Government agencies for purposes of their audits, investigations and other oversight activities;</li> <li>• To government authorities to prevent child abuse or domestic violence;</li> <li>• To the FDA to report product defects or incidents;</li> <li>• To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;</li> <li>• When required by court orders, search warrants, subpoenas and as otherwise required by the law.</li> </ul> <p><b>Patient Rights</b> As our patient, you have the following rights:</p> <ul style="list-style-type: none"> <li>• To have access to and/or a copy of your health information;</li> <li>• To receive an accounting of certain disclosures we have made of your health information;</li> <li>• To request restrictions as to how your health information is used or disclosed;</li> <li>• To request that we communicate with you in confidence;</li> <li>• To request that we amend your health information;</li> <li>• To receive notice of our privacy practices.</li> </ul> <p>If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.</p> <p>If you believe that your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.</p> <p>Requested medical records will be provided <i>within 30 days of the date of request.</i></p>		
1.								
2.								
3.								
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<b>ACKNOWLEDGEMENT OF AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES</b>								
I, the patient or legal representative have reviewed the above information and agree to allow Precision Foot and Ankle, P.A. doctors and staff to proceed with treatment of the above-mentioned payment and agree to the above terms of service.								
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<b>Signature of Patient or Legal Representative</b>								
<b>Date</b>								



## Financial Policy

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and HMO insurance plans in our area. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help. If a referral is required but not on file, you will personally be financially responsible for the visit.

We will bill your insurance company as a courtesy to you. **All co-payments are due at the time of your visit. If you have an unmet deductible we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible. You are responsible for all fees not covered by your insurance company or transferred to patient responsibility by your insurance carrier.**

If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.

**Balances/Collection Fees:** If balances are not paid within **30 days** from the statement date a **\$10.00 rebilling fee** will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding account balances. Past due accounts more than **90 days** will be turned over to our collection agency and a **30% fee** of the balance due will be added to cover collection costs. I also understand that failure to pay my bill implies discontinuation of podiatry services.

Physician phone calls without an appointment are billed at \$25 per 5 minutes. The billable time includes phone and physician documentation time. Most insurances will not cover this charge and you agree to be financially responsible if you request to speak to the doctor without a scheduled appointment.

Complete payment for all podiatry soft goods, medical products and supplies are due at the time they are dispensed. There are no refunds of any kind on products dispensed including custom orthotics, fracture boots, products, etc.

A 24-hour notice is mandatory for cancellation of appointments. If you cancel in less than 24 hours, you will be charged a **\$50 cancellation fee**. If you fail to show for an appointment with calling you personally will be charged a **\$100 no-show fee**. We will try to accommodate you in rescheduling your appointment as soon as possible.

You consent to receiving periodic email marketing messages for educational and general information services. If you would like to opt out of receiving these communications, please initial here \_\_\_\_\_

I have read the above policy and understand my financial responsibility to Precision Foot and Ankle for medical services rendered. I agree to pay any balance due/or unpaid by my insurance carrier for myself or the below named person.

**Financially Responsible Party:**

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Parent or Authorized Representative: \_\_\_\_\_ **Date:** \_\_\_\_\_