Family Foot Care

Name: _____ **Birthdate:** _____-_____-_____ **Age:** _____
First Last Middle

Who is your primary care doctor/family doctor? _____ Last Date Seen Primary Dr.: _____-_____-_____

Whom may we thank for referring you? _____

Sex: M F **Race:** Caucasian African American Hispanic Asian Other: _____

Email Address: _____

Mailing Address

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Do you prefer [ ] text or [ ] voice appointment reminders?

Employer: _____ Patient's Occupation: _____

If Married, Name of Spouse: _____ Spouse Date of Birth: _____-_____-_____

Spouse Employer: _____ Spouse Phone Number: _____

In Case of Emergency, contact: _____ Phone: _____

Relationship: _____

Insurance Information
Must Present Insurance Card

Primary Insurance: _____ **ID #** _____

Who is the Insured? _____ **Insured Date of Birth:** _____-_____- _____

Secondary Insurance: _____ **ID #** _____

Who is the Insured? _____ **Insured Date of Birth:** _____-_____- _____

I understand that if any of the insurance information I have provided in incorrect or if I fail to notify the office of any insurance changes, I am responsible for all physician charges. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Family Foot Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
I have reviewed this information and is correct to the best of my knowledge.

Print Name (please print)**:** _____

Patient Signature _____ Date _____

If Minor, Parent Signature:

_____ Date _____

Family Foot Care

NAME: _____ Date: _____

Briefly describe your symptoms/area of pain: _____ Date Began: _____

Do you drink alcohol? [ ] Yes [ ] No **Weight:** _____ **Height:** _____

Do you smoke? [ ] Yes [ ] No ***Former smoker?*** [ ] Yes [ ] No ***Do you Vape?*** [ ] Yes [ ] No

CHECK ANY THAT APPLY:

AIDS/HIV	[ ] Yes [ ] No	Thyroid problems	[ ] Yes [ ] No	Artificial Heart Valve	[ ] Yes [ ] No
Anemia	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No	History of Gout	[ ] Yes [ ] No
Arthritis	[ ] Yes [ ] No	Heart Disease	[ ] Yes [ ] No	Low blood pressure	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	High Blood Pressure	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No

PREVIOUS SURGERIES OR SURGICAL PROCEDURES: (circle)

FOOT ANKLE ARM HAND KNEE HIP BACK LIVER KIDNEY NECK CANCER

Other: _____

Are you now or have you been under any other doctor's care during the last year? [ ] Yes [ ] No

If yes, explain: _____

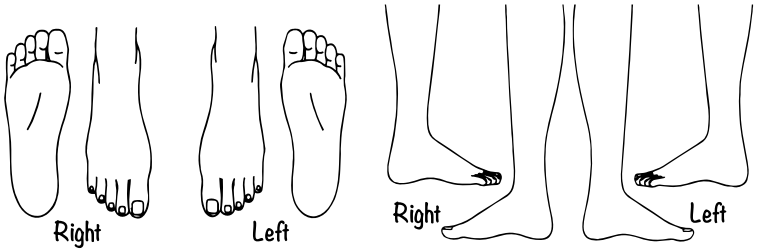
FAMILY HISTORY:

Condition:	Mother	Father
Diabetes:	[ ] Yes [ ] No	[ ] Yes [ ] No
Heart Disease:	[ ] Yes [ ] No	[ ] Yes [ ] No

Other: _____

_____

MARK AREAS OF CONCERN/PAIN:



CURRENT MEDICATIONS: ***Do you take blood thinner?*** [ ] Yes [ ] No

(list all prescriptions, vitamins, over-the-counter medications) _____

_____

_____

_____

Pharmacy Name: _____City:_____Pharmacy Number: _____

ALLERGIES: ☐ **Check here if you have NO MEDICATION ALLERGIES**

[ ] Adhesive/Tape/Latex	[ ] Demerol	[ ] Aspirin	[ ] Other. Please specify:
[ ] Codeine	[ ] Penicillin	[ ] Iodine	_____
[ ] Local Anesthetics	[ ] Novocain	[ ] Sulfa	

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

Patient (or parent of minor child) Signature:

_____ Date _____

Family Foot Care

Patient Authorization for Contact

Patient Name (please print)**:** _____

Purpose of Request:

I authorize Family Foot Care to disclose my protected health information in the following manner:

Telephone: _____

[ ] leave detailed messages on my voicemail

[ ] leave messages with only call-back number (includes staff member name and doctor's office name) on my voicemail

Can we call your name in the lobby? [ ] Yes [ ] No

I give my permission to discuss any information from Family Foot Care with the following person/s:

Name: _____ ***Relationship:*** _____

Name: _____ ***Relationship:*** _____

Name: _____ ***Relationship:*** _____

* HIPAA PRIVACY NOTICE available upon request in office

Patient Communication Transmittal Consent

Our doctors strive to maintain detailed and accurate medical records of your health care. This goal requires both verbal and written data to be entered into your medical record not only by physicians, but also by office staff, nurses and medical scribes. Verbal communication may be monitored during your visit to enable such detailed and accurate records to be created in a timely manner. All such communication is confidential and protected in order to maintain the privacy of your health information. By your signature below, you agree and consent to such monitoring for record keeping purposes. If you do not wish to have such communication monitored, you may opt out of the transmission by informing your physician of such decision.

I, _____, agree and consent to the monitoring of verbal communications between myself and my physician for record keeping purposes.

Print Name (please print)**:**_____

Patient Signature_____ Date_____

If Minor, Parent Signature:

_____ Date _____

Family Foot Care

Financial Policy

All deductibles, co-pays, and co-insurance are **due at the time services are rendered.** Payments can be made by check, cash, Visa, MasterCard, or Discover.

If you have medical insurance, a claim will be filed with your insurance. Our office participates in many insurance plans. This means a discounted fee is accepted for many services. The co-pays, deductible, and co-insurance that are deducted from the final allowable fee are the responsibility of the patient or parent if patient is a minor.

These allowable fees with insurance companies can (and will) change often. Many change these "allowable fees" throughout various months of the year, while Medicare usually changes on a calendar year. Since these are somewhat un-predictable, there may be a balance after your insurance pays their amount.

A statement will be sent for any remaining balance. After 90 days any unpaid amounts will have a $20.00 collection fee added and will be forwarded to a collection service. Further interest and fees will be added through assigned collection service accordingly to their policies.

Cancellations: We require a 24-hour notice if you must cancel of reschedule your appointment. If you cancel the same day as your appointment, this will be considered a missed appointment. We reserve the right to charge a $50.00 fee for no-show/late cancellations.

No-Call / No-Show: 3 no-call/no-show appointments will be grounds from dismissal from the practice. Upon your request and written authorization, we will release your records to the doctor of your choice.

The cancellation and no-show fee are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Print Name (please print)**:**_____

Patient Signature_____ Date_____

If Minor, Parent Signature:

_____ Date _____