

PATIENT INFORMATION

NAME _____

ADDRESS _____

PRIMARY PHONE _____ WORK PHONE _____

EMAIL _____

DATE OF BIRTH ____/____/____

MALE/FEMALE

MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY ____ - ____ - ____ EMPLOYER _____

PRIMARY DOCTOR _____ REFERRED YOU HERE? Y/N

INSURANCE CARRIER'S NAME _____ DOB _____

RESPONSIBLE PARTY'S NAME _____ PHONE _____

EMERGENCY CONTACT PHONE NUMBER _____

EMERGENCY CONTACT NAME _____

AUTHORIZATION TO RELEASE INFO

I authorize the release of my medical/personal information to process my insurance claim.

SIGNATURE _____ **DATE** _____

AUTHORIZATION TO PAY BENEFITS TO THE DOCTOR

I authorize and request payment to be made directly to First Podiatry/Jane Koch/David Reynolds for any healthcare benefits due under the terms and conditions of my insurance policy for services rendered or devices purchased.

SIGNATURE _____ **DATE** _____

ACKNOWLEDGE OF GOVERNMENT PRIVACY ACT

I understand the Government's Privacy Act (HIPAA) and understand that I may obtain a copy of this information if needed.

SIGNATURE _____ **DATE** _____

FIRST PODIATRY FINANCIAL POLICY

I understand that if any unpaid balance is assigned to a third party collection agency or placed with an attorney to obtain judgement or otherwise satisfy payment on my account, a collection fee of 33 1/3% of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs if a judgement is granted against me. I authorize First Podiatry, PC and HSC Medical Billing and Consulting, LLC to contact me by telephone at any of the numbers provided on my patient information sheet, including my wireless phone of me and/or my spouse, which could result in charges for me/us. I acknowledge that my spouse or I may be contacted by sending text messages, and/or emails, using any email address I have provided. Furthermore, I also authorize methods of contact that may include using pre-recorded and/or artificial voice messages and/or automatic dialing services, if applicable.

I agree to be financially responsible for any/all deductibles, coinsurance, copays, and/or procedures that are non-covered or excluded from my insurance plan.

I agree to pay \$30 if I have a check returned for insufficient funds or account closure.

I agree that it is my responsibility to know what procedures are covered under my insurance plan. I am also responsible for knowing if the procedure or product needs prior authorization.

I agree that if I am prescribed CUSTOM MADE ORTHOTICS, that I am responsible for the payment of these orthotics, regardless if I pick them up or not. These are custom made devices and cannot be returned.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY/REVIEW OF SYSTEMS

NAME _____ DATE _____

HEIGHT _____ WEIGHT _____ DOB _____

TOBACCO USE? _____ HOW MUCH? _____ HOW LONG? _____

ALCOHOL USE? _____ HOW MUCH? _____

DRUG USE? _____

LIST PAST SURGERIES (DATE AND SURGERY) _____

HOSPITALIZATIONS IN PAST YEAR (WHY?) _____

PLEASE CIRCLE IF YOU HAVE:

WEIGHT LOSS

CHEST PAIN

BLOOD IN URINE/FECES

NUMBNESS

FATIGUE

HEART ATTACK

URINARY ISSUES

TINGLING

FEVER

FAINING

ANXIETY

TREMORS

GLASSES/CONTACTS

SHORTNESS OF BREATH

DEPRESSION

MEMORY LOSS

CATARACTS

SWOLLEN ANKLES

BIPOLAR

PREGNANCY

BLINDNESS

BLOOD CLOTS

ALCOHOLISM

NURSING

DIFFICULTY HEARING

POOR CIRCULATION

EASY BRUISING

HEADACHES/MIGRAINES

PERSISTANT COUGH

SWOLLEN GLANDS

VERTIGO

COUGHING BLOOD

JOINT PAIN/SWELLING

DIZZINESS

WHEEZING

MUSCLE PAIN

SINUS PROBLEMS

HEARTBURN/GERD

BACK PAIN

ALLERGIES

NAUSEA/VOMITING

MOLE CHANGES

SORE THROAT

CONSTIPATION

RASH

HEART MURMUR

DIARRHEA

ITCHING

PALPITATIONS

JAUNDICE

ECZEMA/PSORIASIS

PLEASE CIRCLE PAST ILLNESSES/ISSUES:

- | | | | | |
|--------------------|---------------------|--------------------|----------------------|------------------|
| ALCOHOLISM | EPILEPSY/SEIZURES | HEPATITIS B OR C | VARICOSE VEINS | HIGH CHOLESTEROL |
| ANEMIA | GLAUCOMA | LUNG DISEASE | RHEUMATOID ARTHRITIS | HIV/AIDS |
| ASTHMA | HEART ATTACK | BIPOLAR | SKIN ISSUES | LUPUS |
| CANCER | HIGH BLOOD PRESSURE | SCHIZOPHRENIA | STROKE | OTHER IMMUNE |
| DIABETES | HEART DISEASE | OTHER MENTAL ISSUE | THYROID DISEASE | AMPUTATIONS |
| DRUG USE | KIDNEY DISEASE | OSTEOARTHRITIS | TUBERCULOSIS | OTHER |
| DEPRESSION/ANXIETY | LIVER DISEASE | OSTEOPOROSIS | STOMACH ULCERS | |

PLEASE EXPLAIN ANY ABOVE CONDITIONS: _____

CURRENT MEDICATIONS/DOSAGE

DRUG ALLERGIES/REACTION
