

NEW PATIENT INTAKE FORM

Welcome to our practice

CHART # _____

PATIENT INFORMATION

LEGAL NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

SEASONAL ADDRESS: _____
STREET CITY STATE ZIP

DATES AT SEASONAL ADDRESS: _____ Thru _____ PREFERRED WAY OF CONTACT: HOME WORK CELL
Month Month

PHONE: HOME () WORK () CELL ()

EMAIL: _____ I AUTHORIZE EMAIL CONTACT YES NO

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS #: 000-00- _____ SEX: MALE FEMALE

MARITAL STATUS MARRIED SINGLE SEPARATED OTHER PREFERRED LANGUAGE: _____

EMPLOYED: YES NO EMPLOYER: _____ Occupation: _____

EMERGENCY CONTACT: _____ PHONE: () _____
NAME / RELATION

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE : _____

RACE: WHITE BLACK HISPANIC ASIAN AMERICAN INDIAN OTHER _____

ETHNICITY: AFRICAN AMERICAN AMERICAN AMERICAN INDIAN HISPANIC ITALIAN OTHER _____

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY. IF THE PATIENT IS A MINOR OR UNDER THE SUPERVISION OF A LEGAL GUARDIAN, THEN THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION. IF THIS DOES NOT APPLY, THEN YOU MAY SKIP TO THE NEXT SECTION.

GUARANTOR INFORMATION

NAME: : _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () WORK () CELL ()

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS#: 000-00- _____

EMPLOYED: YES NO EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR INSURANCE BENEFITS? YES NO

PRIMARY INSURANCE NAME: _____ POLICY ID #/GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS#: 000-00- _____

SECONDARY INSURANCE NAME: _____ POLICY ID #/GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS#: 000-00- _____

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE. IT WILL ASSIST THE DOCTOR IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION IS CONFIDENTIAL.

MEDICAL HISTORY:

REASON FOR YOUR VISIT : _____

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR (DATE)? _____

PLEASE DESCRIBE YOUR PAIN / DISCOMFORT: BURNING NUMBNESS SHARP OTHER _____

WHAT MAKES YOU PAIN / DISCOMFORT BETTER? _____

WHAT MAKES YOUR PAIN / DISCOMFORT WORSE? _____

HAS THIS CONDITION BEEN PREVIOUSLY TREATED? YES NO HOW AND WHEN? _____

HAVE YOU HAD PRIOR SURGERY ANY WHERE ON YOUR BODY? YES NO IF YES, **PLEASE LIST TYPE AND DATE OF SURGERY:**

| | | | | | |
|----|----|----|-----|-----|-----|
| 1. | 2. | 3. | 4. | 5. | 6. |
| 7. | 8. | 9. | 10. | 11. | 12. |

| | | |
|-----|--------|----------------------------------|
| BP: | PULSE: | Last primary doctor appointment: |
|-----|--------|----------------------------------|

| | | |
|--------|--------|-----------|
| HEIGHT | WEIGHT | SHOE SIZE |
|--------|--------|-----------|

FLU VACCINE THIS YEAR: YES (date: _____) NO

PNEUMOCOCCAL VACCINE YES (date: _____) NO

LAST TETANUS WITHIN 10 YEARS YES (date: _____) NO

OUR OFFICE GROWS MAINLY BY REFERRAL FROM OTHER PATIENTS. WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE YOU BEING TREATED FOR OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING?

| | | | |
|---|--|-----------------------|--|
| ALCOHOLISM | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART ATTACK | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ANEMIA | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEPATITIS OR JAUNDICE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ARTHRITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIGH BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASTHMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV / AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BRONCHITIS OR EMPHYSEMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | KIDNEY TROUBLE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CANCER OR TUMOR | <input type="checkbox"/> YES <input type="checkbox"/> NO | MITRAL VALVE PROLAPSE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHOLESTEROL / TRIGLYCERIDES | <input type="checkbox"/> YES <input type="checkbox"/> NO | RHEUMATIC FEVER | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DIABETES (Type I, II, Gestational) | <input type="checkbox"/> YES <input type="checkbox"/> NO | STOMACH ULCERS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Last Blood Sugar # / A1C _____ How Long? _____ | | STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DRUG ABUSE | <input type="checkbox"/> YES <input type="checkbox"/> NO | THROMBOPHLEBITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| EPLIEPSY OR SEIZURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | THYROID DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| GOUT | <input type="checkbox"/> YES <input type="checkbox"/> NO | TUBERCULOSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DO YOU REQUIRE PREMEDICATION BEFORE DENTAL PROCEDURES (ANTIBIOTICS) | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED TO ANY OF THE FOLLOWING?

| | | | |
|-------------------------|--|--|--|
| PENICILLIN | <input type="checkbox"/> YES <input type="checkbox"/> NO | GENERAL ANESTHESIA | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASPIRIN | <input type="checkbox"/> YES <input type="checkbox"/> NO | LIDOCAINE/NOVACAINE (LOCAL ANESTHESIA) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BAND AIDS / TAPE | <input type="checkbox"/> YES <input type="checkbox"/> NO | RADIOGRAPHIC CONTRAST / DYE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CODEINE | <input type="checkbox"/> YES <input type="checkbox"/> NO | SEDATIVE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| IODINE | <input type="checkbox"/> YES <input type="checkbox"/> NO | SULFA DRUGS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Other not listed? _____ | | LATEX | <input type="checkbox"/> YES <input type="checkbox"/> NO |

SOCIAL HISTORY:

| | | | |
|--|---|-------------------------------------|--|
| DO YOU USE TOBACCO? | <input type="checkbox"/> YES <input type="checkbox"/> NO | DO YOU USE RECREATIONAL DRUGS? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| IF YES, HOW MANY PACKS PER DAY AND FOR HOW LONG? | _____/_____ | DO YOU EXERCISE ON A REGULAR BASIS? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ARE YOU PREGNANT? <i>IF YES, DELIVERY DATE?</i> | <input type="checkbox"/> YES <input type="checkbox"/> NO _____ | ARE YOU NURSING? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DO YOU DRINK ALCOHOL? | <input type="checkbox"/> YES <input type="checkbox"/> NO | DO YOU DRINK CAFFEINE? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Family History

PLEASE LIST YOUR RELATIONSHIP TO THE FAMILY MEMBER WHO HAS HAD THE FOLLOWING PROBLEMS:

| | | | | | |
|--------------------|--|-------|----------------|--|-------|
| BLEEDING DISORDERS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | KIDNEY DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| CANCER | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | MENTAL ILLNESS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | RHEUMATOLOGY | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| HEART DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| HIGH BLOOD DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | OTHER | | _____ |

REVIEW OF SYSTEMS

CARDIOVASCULAR: **NONE**

- CALF PAIN WITH EXERCISE / WHILE SLEEPING CHEST PAIN/HEART ATTACK
 CONGESTIVE HEART FAILURE HEART FAILURE PALPITATIONS

CONSTITUTIONAL SYMPTOMS: **NONE**

- FEVER CHILLS SWEATS WEIGHT LOSS

ENDOCRINE:

NONE

- EXCESS SWEATING FREQUENT/DIFFICULTY URINATING
 OFTEN FEELING HOT/COLD OFTEN HUNGRY OFTEN THIRSTY
 PANCREITIS PROSTATE PROBLEMS

GASTROINTESTINAL:

NONE

- ACID REFLUX BLOOD IN STOOL CONSTIPATION
 DECREASE IN APPETITE DIARRHEA NAUSEA
 VOMITING

HEAD, EYES, EARS, NOSE, AND THROAT: **NONE**

- CATARACTS CONTACTS DENTURES
 DIFFICULTY SWALLOWING DIZZINESS DOUBLE VISION
 EYEGASSES NECK PAIN NOSE BLEED
 RINGING IN EARS SORE THROAT

HEMATOLOGICAL/LYMPHATIC:

NONE

- BLEEDING ABNORMALITIES LUMP IN GROIN/ARMPIT SWOLLEN GLANDS

INTEGUMENTARY (SKIN):

NONE

- BIRTHMARKS CHANGES IN SKIN COLOR ECZEMA
 GROWTH ON SKIN HAIR LOSS LESIONS
 PIERCING RASH
 RECURRENT INFECTIONS SENSITIVITY TO SUNLIGHT TATTOOS
 SKIN ULCERS / WOUNDS IN THE PAST

MUSCULOSKELETAL:

NONE

- BURSTITIS JOINT PAIN/SWELLING/STIFFNESS
 PRIOR FRACTURE/SPRAINS TENDONITIS WEAKNESS OF LIMBS

NEUROLOGICAL:

NONE

- CONFUSION FAINTING INSOMNIA MIGRAINES
 NERVOUS DISORDERS NEUROPATHY (LOSS OF SENSATION) POOR BALANCE
 SPEECH DIFFICULTIES

PSYCHIATRIC:

NONE

- DEPRESSION NERVOUSNESS TENSION

RESPIRATORY:

NONE

- COUGH DIFFICULTY BREATHING SHORTNESS OF BREATH
 WHEEZING

To the best of my knowledge, the questions above were accurately answered. I understand that providing inaccurate information can be dangerous to my health.

| | |
|--|--------------------|
| Patient name and signature of patient / parent / POA: | |
| | (Signature) (Date) |
| Physician's signature: | |
| | (Signature) (Date) |

OFFICE POLICY

Welcome to Our Office

Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining the health of your feet. Our practice will strive to provide you with the finest quality podiatric care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments

If you are unable to keep an appointment please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule. You may be charged the cost of the scheduled visit. If you have a scheduled surgical appointment and is not cancelled 1 week prior to scheduled date, you will be charged a \$250 surgical set up fee. These fees are not covered by your insurance.

Leaving Messages

Our office policy is to leave generic, harmless information on answering machines. We would like to accommodate our patients and can do so by initialing next to your preference.

1. _____leave very little information.
2. _____please call # _____and leave specific details.
3. _____please leave as much information as possible on the machine or with anyone who answers my phone.

Transferring Records

If you want to have copies of your records, you must authorize us to include all relevant information, including your payment history upon request. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history. **There will be a \$10 copying fee per film for x-rays.**

Financial Policy

This is an agreement between Albany Family Foot and Ankle Services PC, as creditor and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the Albany Family Foot and Ankle Services, P.C.. By executing this agreement you are agreeing to pay for all services rendered.

Insurance

Insurance is a contract between you and your insurance company. (We are not a party to this contract, in most cases). We will bill your primary insurance company only if we are a contracted participating provider. We will accept secondary insurances for Medicare only, as long as it is medigapped (automatic crossover). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what podiatric coverage is available on your policy. This can only be done on the day of your appointment if time permits. **You as the policyholder are primarily responsible to verify benefits.** We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Referrals

If your insurance company requires a referral and/or preauthorization/pre-certification **you are responsible for obtaining it.** We most likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Workers Compensation

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Required Payments

Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payment Options

You may choose to pay cash, check, or credit card on the day that the treatment is rendered.

Returned Checks There is a fee (currently \$25) for any checks returned by the bank.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Payments

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Finance Charge

A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at an annual percentage rate of one percent (1%) per month or an annual percentage rate of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of our account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and the subtracting any payments or credits applied to the account during that time. The minimum finance charge is \$50.00.

FMLA and Disability Forms

There will be a \$20.00 charge for completing FMLA and disability paper work. Please submit paper work one week prior to due date.

Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Albany County, NY

Waiver of Confidentiality

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

PATIENT'S SIGNATURE

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **NOTICE OF PRIVACY PRACTICES** by the **ANKLE + FOOT CENTER** and that I have read (or had the opportunity to read if I so chose) and understood the notice.

PATIENT'S SIGNATURE

DATE

I GIVE AUTHORIZATION TO DISCUSS MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

| | | |
|---------------|-----------------------|------------------------|
| _____ NAME | _____ RELATIONSHIP | _____ DATE OF BIRTH |
| _____ NAME | _____ RELATIONSHIP | _____ DATE OF BIRTH |

MEDICAL INFORMATION RELEASE

I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

PATIENT'S SIGNATURE

DATE

PHARMACY INFORMATION:

PHARMACY NAME : _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

DO YOU TAKE MEDICATION ON A DAILY BASIS, INCLUDING PILLS, INJECTABLES, OR HERBS? YES NO SEE ATTACHED LIST

| | |
|------------------|---------|
| Medication name: | Dosage: |
|------------------|---------|

| | |
|------------------|---------|
| Medication name: | Dosage: |
|------------------|---------|

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| Medication name: | Dosage: |
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| Medication name: | Dosage: |
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| Medication name: | Dosage: |
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| Medication name: | Dosage: |
|------------------|---------|

I authorize Ankle + Foot Center, PA to download my medication history and Rx benefits into my account from an Rx clearinghouse.

PATIENT'S SIGNATURE

DATE:

