Patient Information Sheet

Welcome to our Office…

***Attention*: Please complete the front and back of this form, write N/A where applicable, and sign both sides. Thank you!**

Social Security#

First Name: **Last Name**: **Middle Initial:**

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Emergency Contact:

Emergency Telephone#: (_____) _____

Employer Name:

Employer's Address / City / State / Zip

Referring Doctor:

Referring Dr.'s Address / City / State / Zip

Ref. Dr. NPI #

Primary Care Physician:

Primary Care Physician's Address / City / State / Zip

P.C.P. NPI #

Primary Insurance Company Information:

Policy Holder First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____

Policy Holders Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance's Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Secondary Insurance Company Information:

Policy First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____

Policy Holders Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance's Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible party for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First):

Responsible Party's SSN: _____-_____-_____

Relationship to Responsible Party: ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of $25 will be applied.

All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel 24hrs prior to an appointment (no show) will result in a $25 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:_____ Patient's Signature (or parents if under 18 years of age): _____

Attention*: *Please fill out this form COMPLETELY, write N/A where applicable. Thank you!

Primary Care Doctor Name :_____ **Date Last Seen** :_____

Pharmacy Name /Address /Phone :_____

_____

Referred by: **Website ____ Office Sign ____ Mailer____ Newspaper____ Person ____ Other ____**

Current Podiatric Problem:

What is the specific complaint today?_____

How long has it been a problem?_____

What have you done to treat the problem so far?_____

Have you ever been cared for by a Podiatrist? **Yes No** When:_____

Past Medical History: **Height**_____ **Weight**_____ **Shoe Size**_____

____Alzheimer's/Dementia
____Arthritis
____Asthma
____Back Pain
____Balance Problems
____Blood Clot
____Bronchitis/Emphysema/COPD
____Cancer
____Charcot
____Depression/Anxiety
____Diabetes
____Gout
____High Blood Pressure
____High Cholesterol
____Heart Attack
____Heart Disease/Failure
____Hepatitis
____HIV+/AIDS
____Joint Implants
____Kidney Disease
____Liver Disease
____Low Blood Pressure
____Nervous System Problems
____Neuropathy
____Numbness/Cramping/Burning
____Osteoporosis/Osteopenia
____Open Sores/Wounds/Ulcers
____Pacemaker
____Polio/Post-Polio Syndrome
____Pneumonia history
____Screws/Pins/Plates
____Stents
____Stroke
____Skin Disorder
____Swelling in the Feet/Legs
____Thyroid Disease
____Tuberculosis
____Varicose Veins
____Vascular Disease

Do you smoke?
____ Yes ____ No; ____ Pack/Day
____ Former Smoker; ____Years
Do you drink Alcohol?
____ Yes; Frequency_____
____ No
Do Small cuts/bruises heal easily?
____ Yes ____ No
Are you currently Pregnant?
____ Yes ____ No

Past Surgical History (list all past surgeries):_____

_____

Family Medical History (list health conditions of immediate family members):_____

_____

Medication Allergies :_____

Current Medications :_____

_____

I, hereby, give permission to Integrity Foot and Ankle Associates and its designated medical professionals to access and treat my feet/lower extremities using any and all medical, surgical, or orthopedic methods appropriate. **I realize it is my responsibility to research and comprehend all charges from my individual medical insurance, including copays, deductibles, benefits, and exclusions. I am financially responsible for all charges and understand all charges must be paid at the time of service.**

_____ _____

Signature Date