

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M | F  
Last First MI

If other than patient, name of person in charge of appointments, payments, etc.: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: Single | Married | Partnered | Legally Separated | Divorced | Widowed

How did you hear about us? Doctor | Health Fair | Insurance | Google/Web | Friend/Family | Sign | TV  
Other: \_\_\_\_\_

**HOW CAN WE REACH YOU?**

Primary Phone: \_\_\_\_\_ Type: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Type: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

Primary Care Doctor/Practice: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

**OTHER CONTACTS:**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Due to HIPAA regulations**, we will not share your private information with anyone without your consent. Is there a family member or other person you would like to grant permission to speak with us concerning your diagnoses, treatments, or bills?

Yes | No

If yes, who? (Please list name and relationship): \_\_\_\_\_

If anyone other than you will be paying your bills, please complete the following:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Do you have a Legal Guardian or Healthcare Power of Attorney? Yes | No

If yes, Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

*\*\*I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.*

\_\_\_\_\_  
Print Name of Patient (Or Parent/Guardian)

\_\_\_\_\_  
If other than patient, relationship to patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient name: \_\_\_\_\_

### MEDICAL HISTORY

Primary Care Doctor: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Circle if you have ever tested positive for any of the following: TB | Hepatitis | HIV/AIDS | MRSA

Do you have any known medication allergies? Please list:

Other Allergies: None known | Tape | Latex | Iodine | Shellfish | Foods/Other: \_\_\_\_\_

Please attach or write a list of all medications you are currently taking (including prescriptions and over-the-counter medications).

Please list all prior surgeries (include approximate date):

Have you ever had any of the following? (Please select Y or N)

Arthritis	Y	N	If you are diabetic, do you take Insulin?	Yes   No
Cancer	Y	N	Last glucose reading:	_____
Diabetes	Y	N	Last A1C Level:	_____
Fibromyalgia	Y	N	Other conditions:	_____
Gout	Y	N	_____	_____
High Blood Pressure	Y	N	_____	_____
Neuropathy	Y	N	_____	_____

Please select any conditions in your **family's** medical history: Cancer | Diabetes | Gout  
Heart Disease | High Blood Pressure | Stroke | Rheumatoid Arthritis

### SOCIAL HISTORY

Current or past tobacco use? Never | Past use (smoked) | Past use (smokeless)  
Current Use -- Type \_\_\_\_\_ Frequency: Rare | Occasional | Moderate | Daily

Current or past alcohol use? Never | Past use -- Quit \_\_\_\_\_ ago  
Current Use -- Type \_\_\_\_\_ Frequency: Rare | Occasional | Moderate | Daily

Current or past recreational drug use? Never | Past use -- Quit \_\_\_\_\_ ago  
Current Use -- Type \_\_\_\_\_ Frequency: Rare | Occasional | Moderate | Daily

Patient name: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you have any known medical conditions or current symptoms associated with:

Eyes: \_\_\_\_\_ Stomach: \_\_\_\_\_ Chest: \_\_\_\_\_

Ears: \_\_\_\_\_ Intestines: \_\_\_\_\_ Heart: \_\_\_\_\_

Nose: \_\_\_\_\_ Liver: \_\_\_\_\_ Lungs: \_\_\_\_\_

Throat: \_\_\_\_\_ Kidneys: \_\_\_\_\_ Other: \_\_\_\_\_

### CURRENT PROBLEM

What specific problem brings you to our office today? (What part of your foot/ankle/lower leg is causing trouble?)

What is your occupation? \_\_\_\_\_

Any hobbies or other activities that impact how you use your feet? \_\_\_\_\_

Was this problem caused by an injury? Yes | No If yes, please explain:

How long ago did this problem first start? \_\_\_\_\_

How would you describe your pain? No pain | Sharp | Dull | Aching | Burning  
Radiating | Itching | Stabbing | Other \_\_\_\_\_

Since your pain or problem began, has it: Stayed the same | Become Worse | Improved

What makes your pain or problem feel worse? Walking | Standing | Resting | Dress Shoes  
Flat Shoes | Any Closed Toe Shoe | Running | Other \_\_\_\_\_

What makes your pain or problem feel better? \_\_\_\_\_

What treatments/remedies have you tried for this problem? Has any of it worked?

## FINANCIAL POLICY

**Payment is due at the time of service.** Copays will be collected at check-in. If you have an unmet deductible, we will collect 60% of the charges being sent to your insurance. After claims have been processed, any amounts you may have overpaid can be used as a credit toward future visits or refunded directly to you. If your up-front payment does not cover all services, you will receive a bill for any additional amounts your insurance has determined you are responsible for.

### **Discounts available**

Our practice has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a discount under the following circumstances:

- If we are in network with your health insurance plan
- If you are uninsured and being treated as a self-pay patient
- If you are experiencing extreme hardship, you may submit a written request to management to be offered a discount for a limited period of time as determined by the practice.

As of 1/1/2024, our office will be unable to extend any type of discounts other than those listed above.

### **Please note**

- A 3% fee will be charged on all card transactions. This fee can be waived by paying with cash or check. Fee also does not apply if paying with a Health Savings Account or Flexible Spending Account.
- Past due accounts are subject to collections proceedings. All costs incurred (including, but not limited to collection fees, attorney fees, and court fees) will be your responsibility, in addition to the balance due at this office.
- You will be responsible for any charges your insurance may deny, including if you have neglected to inform our office of a change in your insurance coverage.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

## CANCELLATION/NO-SHOW POLICY

If you fail to show up to your scheduled appointment or if you cancel with less than 24 hours notice to the practice, you will be subject to a \$50.00 no-show fee, which must be paid prior to your next visit. This fee may be waived in special unavoidable circumstances with management approval. Patients who no-show two (2) or more times in a 12-month period may be dismissed from the practice and denied any future appointments.

*I have read and understand both the financial policy and the cancellation/ no-show policy.*

**Printed Name of Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_