Associates in Podiatry

(937)399-8011 ◆ (Springfield)

415 Harding Road Springfield, Ohio 45504

Patient Information

Name:____________________ Date of Birth:__________ Age*:________

Address:____________________ City, State:__________ Zip:________

Primary Phone Number:__________ ❑Home ❑Cell ❑Work

Secondary Phone Number:__________ ❑Home ❑Cell ❑Work

SSN:__________ Email:__________

Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Employer:____________________ Occupation:__________

Employer Address:____________________ Employer Phone:__________

Shoe Size:________

Height:______ Weight:______

*If patient is under 18, we will need the following information from a parent or guardian:

Name:____________________ Date of Birth:__________ SSN:__________

Relationship to Patient:__________ Phone (if different from patient):__________

Address (if different from patient):____________________

Referral Information

Who may we thank for referring you?

❑Physician __________

❑Insurance Plan __________

❑Family/Friend __________ ❑Yellow Book ❑Google ❑Internet ❑Walked By/Drove By ❑Former Patient

❑Other __________

Primary Care Physician

To facilitate sharing of information related to your care, please provide the following information.

Primary physician__________

Office Phone Number__________

Date of Last Visit? (approx)__________

Do You Reside in Hospice? ❑Yes ❑No

Do You Reside in a Nursing Home? ❑Yes ❑No

Name of Residence:__________

Insurance Information

Primary Insurance Name:____________________ Identification #:__________

Group #:__________ Who is Responsible for this Account? ❑Self ❑Spouse ❑Parent

Cardholder Info: Name:__________ Date of Birth:__________ SSN:__________

Secondary Insurance Name:____________________ Identification #:__________

Group #:__________ Who is Responsible for this Account? ❑Self ❑Spouse ❑Parent

Cardholder Info: Name:__________ Date of Birth:__________ SSN:__________

Emergency Contact

Name:____________________ Relationship:__________

Primary Phone Number:__________ ❑Home ❑Cell ❑Work

Secondary Phone Number:__________ ❑Home ❑Cell ❑Work

What Brought You in Today?

What is the reason for your visit today? (Indicate foot, ankle, toe, etc.)

____

When is it problematic?:______________________ What makes it better/worse?:____________________

How have you treated it?____

Have you ever been to a podiatrist? ❑Yes ❑No If yes, please list the podiatrist:____________________

Podiatric History - Please indicate your current and past foot problems:

❑Ankle Pain	❑Frequent Ankle Sprains	❑Plantar Fasciitis	❑Tired Feet
❑Athlete's Foot/Foot Fungus	❑Gout	❑Plantar Warts	❑Weakness of Legs or Feet
❑Bunions	❑Heel Pain	❑Thick, Discolored Toenails	❑Varicose Veins
❑Corns and Calluses	❑High Arch	❑Recurrent Foot/Leg Wounds	❑Other:____________
❑Curly Toes/Hammer Toes	❑Ingrown Nails	❑Shooting/Aching Foot Pain	____________
❑Flat Feet	❑Neuropathy	❑Swelling in Ankles or Feet	____________

Lifestyle

What is your activity level? ❑Not active ❑Somewhat active ❑Moderately active ❑Highly Active

Do you exercise/participate in athletic activities? ❑Yes ❑No

What activities do you participate in and how frequently?

____

Do you travel frequently? ❑Yes ❑No

Do you smoke/use tobacco? ❑Yes ❑No

Do you drink alcohol? ❑Yes ❑No

Do you drink coffee/other caffeinated drinks? ❑Yes ❑No

Do you use recreational drugs? ❑Yes ❑No

Allergies - Please list any and all allergies that you have. Check none if you have no known allergies:

❑None	❑Codeine	❑Local Anesthetics	❑Seafood	❑Other:__________
❑Adhesive/Tape	❑Demerol	❑Novocain	❑Sulfa	__________
❑Aspirin	❑Iodine	❑Penicillin	❑Bee or Insect Stings	__________

Please indicate the severity of each allergy indicated above (severe, mild, moderate):____________________

____

What happens with each allergic reaction? (skin rash, breathing problems, stomach ailments, etc.)____________

____

____

Medical History - Please indicate if you have had any of the following conditions:

❑Arthritis	❑Circulatory Problems	❑Hepatitis or Jaundice	❑Shortness of Breath
❑Artificial Valves or Joints	❑Depression	❑HIV/AIDS	❑Stroke
❑Asthma	❑Diabetes	❑Kidney Disease	❑Tuberculosis
❑Back Problems	❑Fainting / Dizziness	❑Melanoma	❑Ulcers
❑Bleeding Disorders	❑Fibromyalgia	❑Osteoarthritis	❑Weight Loss, unexplained
❑Cancer	❑Headaches	❑Osteoporosis	❑Other:____________
❑Chemical Dependency	❑Heart Disease	❑Phlebitis	____________
❑Chest Pain	❑Hemophilia	❑Rheumatic Fever	____________

Medications - Please list all medications taken (unless you have provided a separate list)

❑ I brought a list and gave it to the front desk ❑ I take oral contraceptives ❑ I take blood thinners/anti-coagulates

____

Pharmacy Name:______________________________ Pharmacy Number:____________________

Surgeries - Please list all surgeries that you have had:____

____

____

Please list any other hospitalization other than for the surgeries listed:____________________________

____

Other Health Issues - Is there anything else you would like to share with your doctor regarding your health or medications that is not covered above?____

____

____

Assignment & Release

❑ Insurance Authorization

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________and sign directly to Associates in Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

❑ Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Associates in Podiatry for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release for the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, 20%, and non-covered services. Coinsurance, 20% and the deductible are based upon the charge determination of the Medicare carrier.

____ ____________________

Signature of patient or responsible party if patient is under 18 Date

Consent - 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 deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

____ ____________________

Signature of patient or responsible party if patient is under 18 Date

FOR OFFICE USE

Reviewed by: ____Date: ____________________

Associates in Podiatry

Payment Policy & Privacy Practices

Notice of Privacy Practice

Health Information Use and Disclosure. We will use and disclose your health information expressly for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except for the aforementioned reasons, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current notices in effect in our facility.

Additional Disclosure Authority. In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below. This can include: any/all members of immediate family, spouse, employer, school, or any other person.

______________________________	______________________________
Name & Relationship to Patient	Name & Relationship to Patient
______________________________	______________________________
Name & Relationship to Patient	Name & Relationship to Patient

Patient Rights

As our patient, you have the following rights:

- To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
- To receive an accounting of certain health information disclosures we have made.
- To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
- To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete. To receive notice of our privacy practices by requesting a paper copy at any time.

Acknowledgement of Payment Policy/Notice of Privacy Practices

Payment Policy

I have read and fully understand the payment policy of Associates in Podiatry. I acknowledge my rights and responsibilities and agree to act in accordance with the policy set forth. I understand that if I fail to comply with the policy, Associates in Podiatry reserves the right to dismiss me from the practice.

Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read and understood the Notice.

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Signature of patient or responsible party if patient is under 18 Date____________________