Patient Information

Date_____ Pharmacy/Location_____ PCP_____

Patient Name_____ Sex____ Age____ Date of Birth_____

Address_____ Home Phone_____

City/State_____ Zip_____

Mobile Phone_____ Race_____ Primary Language_____ Marital Status_____

Patient's Employer Name & Address_____

Occupation_____ Business Phone_____

In case of an emergency whom may we contact_____

Phone_____ Relationship_____

How were you referred to our office _____

Who is the responsible party (if the patient is a minor or student) _____

Address _____

Does your insurance require prior authorization/referral Yes No

What is your principal foot problem? _____

(I understand that I am financially liable for all costs incurred for all visits if my insurance requires a referral and I fail to obtain one.)

Authorization and release: I hereby authorize payment directly to the doctor for medical benefits otherwise payable to me. I understand that I am financially responsible to the doctor for charges not covered by the assignment. I hereby authorize my physician to release any information requested to support my claim.

Sign by patient or legal guardian _____ Date _____

Patient name _____ Patient DOB _____

Past medical history: Circle all of the conditions/diseases you have now or have had in the past.

Abnormal ECG	Cirrhosis	High Cholesterol	Osteoporosis
Alcoholism	Clotting disorder	HIV	Pacemaker
Allergies	COPD	High Blood Pressure	Psoriasis
Anemia	DVT	Keloid	Psychiatric disorder
Anxiety	Diabetes	Kidney Disease	Rheumatoid arthritis
Bleeding disorder	Diverticulitis	Leg swelling	Seizures
Bronchitis (frequent)	Epilepsy	Liver Disease	Sickle cell anemia
CAD	Gestation Diabetes	Lower extremity swelling	Skin ulcer
Cancer	Gout	Lyme disease	Stomach ulcer
Cerebral Palsy	Hepatitis A B C	Myocardial infraction	Stroke
CHF		MS	Substance abuse
			Tuberculosis
			Thyroid Disease

Other: _____

Review of systems: Circle all of the conditions you have now.

Cardiovascular:	**Musculoskeletal:**	**Skin:**
Chest pain/ Angina	Joint pain	Rash/itching
Palpitations	Joint stiffness	Change in hair
Short of breath walking	Muscle weakness	Change in nails
Short of breath lying flat	Muscle pain/cramps	Change in skin color
Swelling in feet/ ankles	Back pain	
Gastrointestinal:	**Neurological:**	**Constitutional:**
Nausea/vomiting	Numbness/tingling in feet	fever
Acid reflux	Sharp burning pain in feet	Unexplained weight loss
Abdominal pain	Paralysis	
Diarrhea		

Patient Name:_____ Patient DOB:_____

List your medications:_____

_____

List your Allergies to Medications:_____

Medical & Social History:

Have you ever had surgery? Yes No If yes, what kind and when:_____

_____

Did you have any complications related to surgery? Yes No If yes, describe:_____

_____

Use of tobacco: Never Former Current smoker Packs per day_____

Use of alcohol: Never Rare Moderate Daily Recovering

Height:_____ Weight:_____ Shoe size:_____

Family History: Circle all that apply

Arthritis	Heart disease	Rheumatoid arthritis
Bleeding disorder	High Blood pressure	Stroke
Cancer	Muscular dystrophy	Other:_____
Diabetes	Peripheral vascular disease	_____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: circle all that apply.

Home Phone_____ Ok to leave detailed information or leave call back number only

Work phone_____ Ok to leave detailed information or leave call back number only

Written communication: Ok to mail to home or work

I, _____, give Bay State Family Podiatry permission to discuss my health care information with: _____ Relationship:_____

Patient Signature: _____ Date:_____

BILLING POLICY

A billing fee of $10.00 will be added to your account for any balances that we must attempt to collect through mailing a monthly statement after 90 days. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid after 90 days.

If you wish to avoid these charges, you may leave your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover but for which you are responsible.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Bay State Family Podiatry to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

AMEX VISA MASTERCARD DISCOVER

Credit Card Number _____

Expiration Date _____ 3 Digit Code _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City:_____ State:_____ Zip Code: _____

I (We), the undersigned, authorize and request Bay State Family Podiatry to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Bay State Family Podiatry. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notice in writing and the account must be in good standing.

Patient Name print: _____

Patient Signature: _____ Date: _____