D__M__

WELCOME TO PREFERRED FOOTCARE OF MUNCIE, LLC

NAME: ____ **DOB:** ___ - ___ - ___
FIRST **MI** **LAST**

SSN: _______ - _____ - _______ **MARITAL STATUS:** single married separated divorced widowed
(PLEASE CIRCLE)

ADDRESS: ____
STREET **CITY** **STATE** **ZIP**

HOME PHONE: (_____) ______ - _______ **CELL #:** (_____) ______ - _______ **WORK #:** (_____)______ - _____________

NAME OF EMPLOYER: _________________________________**OCCUPATION**: ____________________________________

E-MAIL ADDRESS: ____ **Can we use?: YES NO**
(We will not give your e-mail address out to anyone, for any reason. We will only send important information to you)

EMERGENCY CONTACT: ___________________________________ **RELATIONSHIP:** _______________________________

PHONE NUMBER: (____) ______ - _______

PHARMACY OF CHOICE: ____

INSURANCE INFORMATION

(If your condition is due to an accident or injury from work, auto, or third party, please see Staff.)

For staff:

PRIMARY INSURANCE: _____________________________________ **EFFECTIVE DATE:** ______________ **COPY:** ______

SECONDARY INSURANCE: __________________________________ **EFFECTIVE DATE:** ______________ **COPY:** ______

AUTHORIZATION

I understand that there may be times when Preferred Footcare may need to contact me.

I give Preferred Footcare staff permission to contact me:

❑ At home ❑ Cell phone ❑ At work

I give Preferred Footcare staff permission to leave messages on:

❑ My home answering machine ❑ My work answering machine ❑ My cell phone voicemail

I give Preferred Footcare staff permission to leave messages with: __________________________________

AUTHORIZATION OF MEDICAL RELEASE

I authorize Preferred Footcare Specialists to release:

- Information to specialists that I have been referred to in order to provide proper care.
- Information to any hospital, physician, or nurse practitioner that may be participating in my care.
- Information on my care to my insurance company.
- Information regarding my care to help obtain required pre-certifications as well as insurance payments.

I understand that if my decision to release medical records changes, that it is my responsibility to inform Preferred Footcare Specialists. I also understand that Preferred Footcare Specialists will use current HIPPA standards to release these records.

Signature: ____ Date: _____ - _____ - _____

REVIEW OF SYSTEMS

HEIGHT: _________ **WEIGHT:** _________ **SHOE SIZE:** _________

FAMILY PHYSICIAN: ________________________________ **LAST SEEN:** _____________________________

Have you ever seen a Podiatrist? (If so, by whom and for what type of treatment)**:** ____

Have you ever had a problem with Anesthesia? () Yes () No If yes, please explain: _____________________________________

ALLERGIES: _________________________
____
____
____
____

MEDICATIONS: ____
____
____
____
____

Please check any of the following that pertains to you.

Constitutional:

- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Night sweats
- ❑ Weakness
- ❑ Chills
- ❑ Headaches

Respiratory:

- ❑ Difficulty breathing
- ❑ Cough
- ❑ History of Pneumonia
- ❑ Smoker Packs/day: _______
- ❑ TB exposure
- ❑ Lung or breathing problems

Endocrine:

- ❑ Diabetes Type: ________
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Eat a lot
- ❑ Drink a lot
- ❑ Urinate a lot

Ears:
- ❑ Hearing loss
- ❑ Ringing in the ears
- ❑ Dizziness

Eyes:
- ❑ Glasses
- ❑ Blurred vision
- ❑ Pain/Dry/Red/Watery

Nose:
- ❑ Congestion
- ❑ Sinus problems
- ❑ Bleeding
- ❑ Sneezing

Throat:
- ❑ Pain
- ❑ Difficulty swallowing
- ❑ Hoarseness

Cardiac:

- ❑ Chest pain
- ❑ Murmurs
- ❑ Peripheral Edema
- ❑ Claudication
- ❑ Bleeding problems
- ❑ Blood transfusion
- ❑ Heart problems Type: _______________
- ❑ Hypertension
- ❑ Phlebitis
- ❑ Poor circulation
- ❑ Stroke Type: _____________

Gastrointestinal:

- ❑ Indigestion
- ❑ Reflux
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Abdominal pain
- ❑ Heartburn
- ❑ Liver problems
- ❑ Stomach ulcer
- ❑ Hepatitis exposure

Musculoskeletal:

- ❑ Joint pain
- ❑ Joint swelling
- ❑ Swelling in feet or legs
- ❑ Trauma
- ❑ Trauma to feet or legs
- ❑ Muscle aches
- ❑ Muscle weakness
- ❑ Tremors
- ❑ Back pain
- ❑ Cramping of feet or legs
- ❑ Gout

Genitourinary:

- ❑ Frequent urination
- ❑ Urgency of urination
- ❑ Blood in the urine
- ❑ Kidney problems

Blood/Lymph:

- ❑ Anemia
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Swollen glands

Immune:

- ❑ Cancer
- ❑ Infectious/contagious disease
- ❑ Poor healing

Neuro/Psych:

- ❑ Seizures
- ❑ Passing out
- ❑ Coordination problems
- ❑ Depression
- ❑ Anxiety
- ❑ Insomnia

Surgeries: ____________________________
____
____

Other: _____________________________
____
____

FAMILY MEDICAL HISTORY:

ILLNESS/DISEASE **IF DECEASED/CAUSE OF DEATH**

Father: ____ __________________________________

Mother: ____ __________________________________

Siblings: ____ __________________________________
____ __________________________________
____ __________________________________

Children: ____ __________________________________
____ __________________________________

PATIENT SOCIAL HISTORY:

Use of alcohol: Never_____ Rarely_____ Moderate_____ Daily_____ Amount_____

Use of tobacco: Never_____ Previously, but quit______weeks/months/years ago Current pack/day_______

Use of drugs: Never_____ Type/Frequency____

History of addiction to prescription or non-prescription drugs: Never__________ Type_____________________

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HEALTH INFORMATION PRIVACY PRACTICES ACT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE: ____ DATE: ____-____-____

FINANCIAL AGREEMENT

I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to ensure insurance payments are processed and paid timely. In the case of default payment, I promise to pay any legal interest on the balance due, along with any collection costs/fees, court costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature: ____ Date: _____ - _____ - _____

MEDICARE SIGNATURE ON FILE (LIFETIME)

I request that payment of authorized Medicare benefits be made to Preferred Footcare Specialists on my behalf for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine those benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of 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 and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature Date