

PRECISION PODIATRY
Welcome to our practice

Patient: _____ DOB ___/___/___ Age _____ Date: _____

Height: _____ Weight: _____ Shoe Size: _____

Reason for visit: _____

Drug Allergies: _____

Medications: _____

Tobacco use: Yes / No Alcohol use: Yes / No

Recreational Drug Use: Yes / No

Medical History (please check all that apply)

- Rheumatic Fever
- Polio
- Diabetes Mellitus
- High Blood Pressure
- Stroke
- Hepatitis
- Gout
- Asthma
- Cancer
- Liver Disease
- Kidney Disease
- Lung Disease
- Stomach Ulcer
- Heart Condition
- Headaches
- Anemia
- Osteoporosis
- Psychiatric Disorder
- Thyroid Problem
- Tuberculosis
- Other _____

List Surgeries (include dates) _____

OVER

Family History (check all that apply)

- Diabetes
- Arthritis
- Stroke
- Cancer
- Heart Attack
- High Blood Pressure
- Birth Defects
- Anesthesia Reaction
- Bleeding Problems
- Other _____

Are you currently suffering from any problems listed below? (Please circle all that apply)

Head: chronic headaches, concussions, dizziness, loss of consciousness

Eyes: glasses, contacts, double vision, blurred vision, blindness, glaucoma, cataracts

Ears: decrease or loss of hearing, tinnitus, chronic earaches, drainage or infections

Throat: chronic tonsillitis, laryngitis, dysphasia, loss of speech, thyroid disorder

Nose: chronic drainage, blockage, epistaxis, sinusitis

CVS: heart attack, high blood pressure, rheumatic fever, chest pain, shortness of breath, fluttering, heart murmur, valvular disease, anemia

Respiratory: asthma, difficulty night breathing, TB, pleurisy, emphysema, pneumonia

G.I.: peptic or duodenal ulcer, chronic nausea, vomiting, diarrhea, constipation, weight gain or loss, jaundice, hepatitis, gallbladder disease, gallstones, blood in stool, hematemesis, colitis, diverticulitis, polyps, appetite disorders

G.U.: chronic kidney or bladder infections, stones, dysuria, pyuria, hematuria, venereal disease

GYN: dysmenorrhea, amenorrhea

Musk.: gout, rheumatoid arthritis, osteoarthritis, trauma, fracture, dislocations

Please tell us whom we can thank for referring you.

Name _____

Please tell us whom to coordinate your care.

Physicians name and number _____

Precision Podiatry

Patient Information (please print clearly)

Name _____ Phone () _____
Last First Middle Initial
Mailing Address _____
City _____ State _____ Zip _____
S.S.# _____ Sex M / F Marital Status _____
Birthdate _____ Age _____ Student / Non student
Employer _____
Work Phone Number _____ Cell _____

Insurance Information

Primary Insurance _____
Policy Holder Name _____
Employer _____
SS# _____ Birthdate _____ Relation to Patient _____

Secondary Insurance _____
Policy Holder
Name _____ Employer _____
SS# _____ Birthdate _____ Relation to Patient _____

Responsible Party

Responsible Party _____ Birthdate ___ / ___ / ___ Relationship to Patient _____
Occupation _____ Employer _____
Employer Address _____ Phone () _____

Emergency Contact

Name _____ Relation to Patient _____
Phone Number _____

If accident, was it related to work ___ auto ___ or other ___? List date of injury ___
and a brief description of how it happened?

Consent for Treatment

In the best of my knowledge, the above information is correct. I hereby give my
permission to Precision Podiatry, its physicians to administer treatment and to perform
such procedures as deemed necessary in the diagnosis and/or treatment of my foot
condition.

Signature of Patient _____ Date _____

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES
INFORMATION _____ (INITIALS).

RESPONSIBILITY STATEMENT

Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your contract with them and with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. By signing this you understand and agree that (regardless of insurance status), you are ultimately responsible for the balance of your account for any professional services rendered. You certify that all the information given is true and correct to the best of your knowledge. You will notify us of any changes in your status or the above information.

No show policy as of August 1, 2001: Patients arriving 15 minutes past their appointment time, may be rescheduled. Any appointment rescheduled with less than 25 hours notice or no show appointments are subject to a \$25.00 fee.

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Precision Podiatry and its physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____ Date _____

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me, or on my behalf to Precision Podiatry and its physicians for any services furnished to me by the provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents needed to determine benefits, of the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____ Date _____