Volunteer Podiatry, PC

Patient Name: _____ **Chart #:** _____

Date of Birth: _____/_____/_____

Patient Information (Please Print)

Date: _____/_____/_____

Patient Name: _____ _____ _____ Date of Birth: _____/_____/_____ Age: ____Sex: M F

Social Security #: _____ - _____ - _____

Home Address: _____ City/State: _____ Zip: _____

May we leave a message?

Home Phone #: (_____) _____ - _____ Yes No

Work Phone #: (_____) _____ - _____ Yes No

Cell Phone #: (_____) _____ - _____ Yes No

Email: _____

Primary Language: _____

Race: _____ Ethnicity: _____

Do you have a legal guardian or Healthcare Power of Attorney? Yes No

If yes, Name: _____ Relationship: _____ Phone #: (_____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____ - _____

Primary Care Doctor: _____ Phone #: (_____) _____ - _____

Pharmacy: _____ Location: _____ Phone #: (_____) _____ - _____

Is there a family member or other person you would like us to share your medical information with?

_____ Yes Name(s) _____ Phone #: (_____) _____ - _____

_____ No

Who referred you to us: _____

Insurance Information

Primary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (_____) _____ - _____

Insured Name: _____ Date of Birth: _____/_____/_____ Employer: _____

ID#: _____ Group #: _____

Secondary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (_____) _____ - _____

Insured Name: _____ Date of Birth: _____/_____/_____ Employer: _____

ID#: _____ Group #: _____

Patient Name: _____ **Chart #:** _____

Date of Birth: ____/____/____

Past Medical History

Acid Reflux/GERD	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Bladder Infections	Y	N
Abnormal Bleeding	Y	N
Blood Clots	Y	N
Blood Transfusions	Y	N
Bronchitis/Emphysema	Y	N
Cancer	Y	N
Diabetes? Type 1 or Type 2 (circle)	Y	N

Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart Disease/Failure	Y	N
Hepatitis	Y	N
HIV/AIDS	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Migraine Headaches	Y	N
Mitral Valve Prolapse	Y	N

Neuropathy	Y	N
Open Sores	Y	N
Pneumonia	Y	N
Polio	Y	N
Rheumatoid Arthritis	Y	N
Sickle Cell Disease	Y	N
Skin Disorder	Y	N
Sleep Apnea	Y	N
Stomach Ulcers	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N

Other Conditions: _____

Weight: _____ Height: _____ Shoe Size: _____

Surgical History

Type of Surgery	Date

Hospitalizations

Reason for Hospitalization	Date

Medications

(Please list all prescription, over the counter and herbal medications. Additional sheet at back if necessary)

Name	Dose	How often do you take?

Patient Name: _____ **Chart #:** _____

Date of Birth: _____/_____/_____

Allergies

Medications: _____

Anesthesia: _____

Foods: _____

□ Tape □ Latex □ Shellfish □ Iodine □ Other: _____

□ None Known

Social History

Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed

Use of Alcohol: □Never □ Quit – How long ago? _____ □ History of alcohol abuse

□ Current Use – Type _____ □ Rare □ Occasional □ Moderate □ Daily

Use of Tobacco: □Never □ Quit – How long ago? _____

□ Current Use – Type _____ □ Rare □ Occasional □ Moderate □ Daily

Use of Recreational Drugs: □Never □ Quit – How long ago? _____ Type: _____

□ Current Use – Type _____ □ Rare □ Occasional □ Moderate □ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? □ 10% □ 25% □ 50% □ 75% □ 100%

Do others depend upon you for their care? □ Children – Age(s): _____ □ Pet(s) – What kind? _____

□ Elderly or disabled family member? □ Other

Exercise: □ Never □ Rare □Occasional □Weekly □ Several times per week □ Daily

Types of exercise: _____

Family History

Do you have a family history of: □ Diabetes Type 1 or Type 2 □ Cancer □ Heart Disease

□ High Blood Pressure □ Stroke □ Coronary Artery Disease □ Thyroid Disease

□ Rheumatoid Arthritis □ Other – Type: _____

Date of Last Flu Shot? _____ Date of Last Pneumonia Shot? _____

Patient Name: _____ **Chart #:** _____

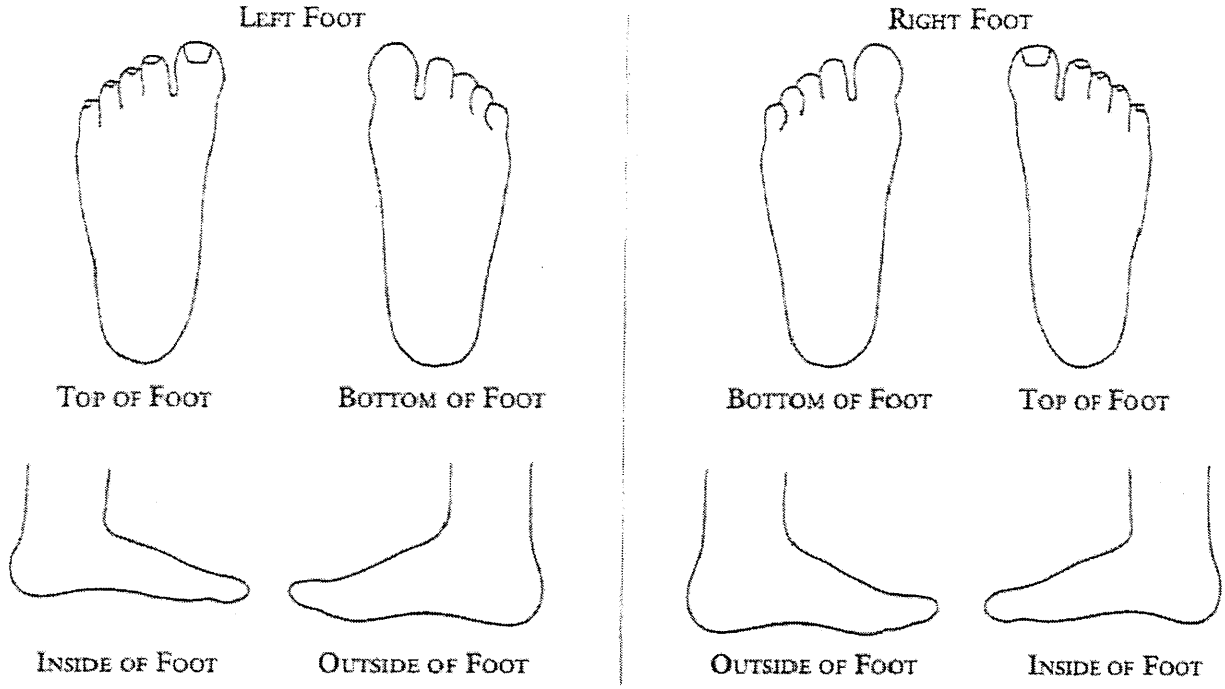
Date of Birth: ____/____/____

Current Problem

What specific problem brings you in to our office today? _____

_____

Where is the pain/problem located? Please mark on the pictures below:



How long ago did this problem first start? _____ □ Days □ Weeks □ Months □Years

Did your pain or problem: □ Begin all of a sudden □ Gradually develop over time

How would you describe your pain? □ No pain □ Sharp □ Dull □ Aching □ Burning
□ Radiating □ Itching □ Stabbing □ Other: _____

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

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

What makes your problem feel worse? _____

What makes your problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? □ Yes (Describe) _____

If yes, was it a work-related injury? □ Yes □ No

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To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I request and give permission for the treatment of my foot condition(s). I have been given the opportunity to and have read the privacy policy of Sandberg Foot Health Center, PC d.b.a. Volunteer Podiatry, PC. I understand that information relating to my medical condition may be released to my insurance company for claims purposes and I hold harmless Sandberg Foot Health Center, PC d.b.a. Volunteer Podiatry, PC for any action taken by present or future insurers as a result of this information.

_____ _____

Print name of patient, parent or guardian Signature of Doctor

_____ _____

If other than patient, relationship to patient Date

_____

Signature

_____ Reviewed and updated by: Date:

Date

_____, DPM _____

_____, DPM _____

_____, DPM _____

_____, DPM _____

_____, DPM _____

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Sandberg Foot Health Center, PC d.b.a. Volunteer Podiatry, PC – Financial Policy

- Your understanding of our financial policies is an essential element of your care and treatment, if you have any questions, please ask to speak with a member of our billing staff.
- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. You will be required to pay the applicable co-payment, co-insurance, and deductible at the time of service. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- If you have insurance coverage with a plan with which we do not have a prior agreement, all charges for your care and treatment are due at the time of service. We will then process a claim for you as a courtesy.
- All co-payments, non-covered services and out of pocket expenses are due at the time of service. We accept Visa, Mastercard, Discover, American Express, cash and personal checks. ** There is a service charge of $25.00 for all returned checks. (Your insurance company does not cover this fee) **
- All health care plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have the proper authorization, you will be responsible for the complete charge. We will attempt to verify benefits for certain specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- It is your responsibility to inform our office of all insurance changes and authorization/referral requirements at the time of service. In the even you do not, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your full responsibility.
- There are certain elective surgical procedures for which we require prepayment. You will be informed by the surgery scheduler in advance if your procedure is one of those. In that event, payment will be due one week prior to the scheduled surgery. Keep in mind that you will incur other charges that can include the facility, anesthesiologist, and laboratory. Our practice is not involved in those financial arrangements.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to the office.
- The parent or guardian accompanying a minor being treated will be responsible for the co-payment at the time of service as well as any further balance due.

I authorize Sandberg Foot Health Center, PC d.b.a. Volunteer Podiatry, PC to file claims to my insurance company.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Patient Name: _____ **Chart #:** _____

Date of Birth: _____/_____/_____

Additional Medications

(Please list all prescription, over the counter and herbal medications. Additional sheet at back if necessary)

Name	Dose	How often do you take?