Chart: _____ Date: _____

Volunteer Podiatry

Patient Information (Please Print)

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M / F

Address: _____

City _____ State _____ Zip _____

May we leave a message?

Home Phone: _____ Y / N

Cell Phone: _____ Y / N

Work Phone: _____ Y / N

Email: _____ Primary Language: _____

Race: _____ Ethnicity: _____

Do you have a legal guardian or Healthcare Power of Attorney? Y / N

If yes, name: _____ Phone: _____

Relationship: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Care/Pharmacy/Referring

Primary Care: _____ Phone: _____

Pharmacy: _____ Phone: _____

Pharmacy location: _____

Referring provider: _____

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

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Phone : _____ Phone : _____

Address: _____ Address: _____

Insured Name: _____ DOB: _____ Insured Name: _____ DOB: _____

ID#: _____ Group: _____ ID#: _____ Group: _____

Employer: _____ Employer: _____

Chart: _____ Date: _____

Medical History:

Height: _____ Weight: _____ Shoe Size: _____

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

Surgical History

Type of Surgery:	Date:	Reason for Hospitalization:

Family History

Do you have a family history of: ☐ Diabetes 1 or 2 ☐ Cancer ☐ Heart Disease ☐ Thyroid Disease ☐ Stroke ☐ Coronary Artery ☐ High Blood Pressure ☐ Rheumatoid Arthritis Other: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Legally Seperated ☐ Divorced ☐ Widowed

Alcohol Use: ☐ Never ☐ Quit- how long ago? _____ ☐ History of Alcohol Abuse
☐ Rarely ☐ Moderately ☐ Daily Type Consumed? _____

Tobacco Use: ☐ Never Quit- how long ago? _____
☐ Rarely ☐ Moderately ☐ Daily Type Consumed? _____

Recreational Drug Use: ☐ Never ☐ Quit- how long ago? _____
☐ Rarely ☐ Moderately ☐ Daily Type Consumed? _____

Employer: _____ Occupation: _____

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

Do others depend on you for their care: ☐ Children (ages) _____ ☐ Pet(s) How many? _____
☐ Elderly or Disabled family members ☐ Other? _____

Do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

Type of exercise: _____

Chart: _____ Date: _____

Allergies:

Allergies to Medications: _____

Anesthesia: _____

Foods: _____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ None Other: _____

Medications:

Please list all prescription, vitamins, and OTC's below.

Chart: _____ Date: _____

Have you had ANY falls in the last year? Y / N Did falls result in injury? Y / N

What specific problem brings you into the office today? _____

_____

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

Left Foot

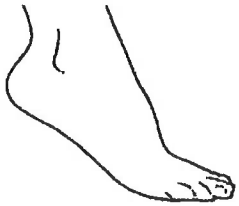
Bottom of foot

Top of foot

Right Foot

Top of foot

Bottom of foot



When did you first notice your problem? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Did your pain or problem: ☐ Begin Suddenly ☐ Gradually developed over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Aching ☐ Burning ☐ Dull

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other: _____

How would you rate your pain on a scale of 1 to 10? (please circle)

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

Chart: _____ Date: _____

From the time your pain/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 tried for your problem? _____

_____

_____

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

_____

_____

Was this problem caused by an injury? If yes, please describe _____

_____

_____

_____

If yes, was this injury work related? ☐ Yes ☐ No

Chart: _____ Date: _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor and office staff of any changes to 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 Heatlh, PC d.b.a Volunteer Podiatry. 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, PC d.b.a. Volunteer Podiatry for any action taken by present or future insurers as a result of this information.

_____ _____

Print name of patient, parent, or guardian Date

_____

If other than patient, relationship to patient

_____

Signature

Chart: _____ Date: _____

Sandberg Foot Health Center, PC d.b.a Volunteer Podiatry
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 insurnace claim for you. You will be required to pay the applicable co-payment, co-insurance, and deductible at the time of service. If payment from your insurance company is not received in a reasonable period, you will be responsible for payment.

If you have insurance coverage with a plan we are not contracted with, all charges for your care and treatment are due at the time of service. We will then process a claim for you as 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 will be a service charge of $35.00 for all returned checks.** (Your insurance company does not cover this fee.)**

All healthcare plans are not the same and do not cover the same services. In the event your health plan determines a service is 'not covered', or you do not have the proper authorization, you will be responsible for the charge(s). We will attempt to verify benefits; however, you will remain responsible for charges to any service deemed not covered. Patients are encouraged to contact their plan(s) for clarification of benefits prior to services rendered.

It is your responsibly to inform our office of all insurance changes and authorizations/referral requirements at the time of service. In the event you do not, you will be responsible for any denied charges.

For most services provided in the hospital, we will bill your health plan. Any balances due is your full responsibility.

There are certain elective surgical procedures for which we require prepayment. You will be informed by the scheduler in advance if this applies to your procedure. At which time, payment will be due one week prior to scheduled surgery. You may also incur charges that can include the facility, anesthesiologist, and laboratory. Those financial arrangements are seperate from our practice.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, and court fees shall be your responsibility in addition to the balance due to the office.

The parent or guardian accompanying a minor is responsible for the co-payment at the time of service and any additional balance that may be accrued.

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

Signature of Patient/Responsible Party: _____

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