PATIENT DEMOGRAPHICS

Patient Information:

Full Name: _____ **DOB:** _____
Social Security Number: _____
Address: _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
E-Mail Address: _____
Gender:☐Male☐Female **Marital Status:**☐Single☐Married☐Divorced☐Separated☐Widowed
Race/Ethnicity:
American Indian/Alaska Origin☐ Asian☐
African American/Black☐ White☐
Native Hawaiian/Pacific Islander☐ Hispanic☐
Other: _____

Insurance Information:

Primary:	**Secondary:**
Insurance Company: _____	Insurance Company: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's DOB: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

Name: _____ **DOB:** _____
Address: _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Gender:☐Male☐Female

Pharmacy Information:

Choice of Pharmacy: _____ **Phone:** _____
Pharmacy Address: _____
Primary Care Physician: _____ **Phone:** _____

Emergency Contact:

Name: _____
Relationship to Patient: _____ **Phone:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

How did you find out about our Practice?

☐ Doctor referral Name: _____
☐ Internet Keyword: _____
☐ Family/Friend Name: _____
☐ Other: _____

Signature: _____ Date: _____

Name/relationship of the responsible party (if not patient): _____

MEDICAL FORM

Patient Name: _____ **DOB:** _____
Reason for visit: _____
How long has this been a problem? _____
When does this occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ All Day ☐ On and Off
Treatments: Please list previous treatments (prescribed and/or home remedies):

_____

_____

Is this visit related to an accident/injury? Yes ☐ No ☐ If yes, **Date of injury:** _____

Past Medical History:

- ☐ Alcohol/Drug Addiction
- ☐ Alzheimer's/Dementia
- ☐ Anemia
  - Type: _____
- ☐ Arrhythmia
  - Type: _____
- ☐ Arthritis
  - Type: _____
- ☐ Asthma
- ☐ Bleeding/Clotting Problems
  - Type: _____
- ☐ Blood Clots (DVT)
- ☐ Cancer
  - Type: _____
- ☐ Depression/Anxiety
- ☐ Diabetes
  - How long? _____
  - HbA1C: _____
  - AM Glucose: _____
- ☐ Emphysema/COPD
- ☐ Glaucoma
- ☐ Gout
- ☐ GERD
  - GI Reflux
  - GI Ulcers
- ☐ Headaches/Migraines
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Hepatitis
  - Type: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney/Renal Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lyme's Disease
- ☐ Nervous System Condition
  - Type: _____
- ☐ Osteoporosis/Osteopenia
- ☐ Peripheral Arterial Disease
- ☐ Pregnancy
  - Due date: _____
- ☐ Rheumatic/Scarlet Fever
- ☐ Schizophrenia
- ☐ Seizures/Epilepsy
- ☐ STD's (Sexually Transmitted Ds.)
- ☐ Sickle cell trait/disease
- ☐ Stroke/TIA's
- ☐ Thyroid Problems
  - Hyper?
  - Hypo?
- ☐ Tuberculosis
- ☐ Other: _____

Family History: Is there any immediate family history of: (please indicate relationship)

☐ Alzheimer's	☐ Cancer	☐ High Blood Pressure
☐ Arthritis	☐ Circulation Problems	☐ Neurological
☐ Bleeding Disorders	☐ Diabetes (I/II)	☐ Strokes
☐ Blood Clots	☐ Heart Disease	☐ Other: _____

Past Surgical History: If YES, please list all surgeries below

_____

_____

Social History:

Do you or have you ever smoked? ☐ Yes ☐ No (If YES, packs per day? _____ how many years? _____)
How long ago did you quit? _____
Do you or did you ever drink alcohol? ☐ Yes ☐ No (If YES, how many drinks per day? ____ per week? _____)
How long ago did you quit? _____
Do you or have you ever used illicit/recreational drugs? ☐ Yes ☐ No
If YES, which ones? _____ How long ago did you quit? _____

Medications: Please list (or attach a list) of all current medications including over the counter with dosages

_____

_____

_____

Allergies: Do you have history of allergies/skin reactions to any of the following? If YES, please list reaction

☐ Adhesive Tape	☐ Iodine	☐ Penicillin	☐ Codeine
☐ Local Anesthesia	☐ Latex	☐ Sulfa Drugs	☐ Cortisone
☐ Food	☐ Aspirin	☐ Demerol	☐ Other: _____

Patient Name: _____ **DOB:** _____

Review of Systems: Please check any of the following that you are currently experiencing or have recently experienced		
General/Constitutional	**Gastrointestinal**	**Integumentary/Skin**
☐ Fever	☐ Nausea	☐ Rashes
☐ Chills	☐ Vomiting	☐ Warts on feet
☐ Malaise	☐ Abdominal Pain	☐ Moles/Lumps/Bumps
☐ Weakness	☐ Heart Burn	☐ Dry Skin/Cracking
☐ Fatigue	☐ Persistent Diarrhea	☐ Open Skin Sore
☐ Night Sweats	☐ Constipation	☐ Calluses
☐ Recent Weight Gain/Loss ☐ How much? _____	☐ Blood in Stools	☐ Nail Problems
Eyes	**Kidney/Urinary/Bladder**	☐ Unusual Skin Discoloration
☐ Double/Blurred Vision	☐ Frequent Urination	☐ Noticeable Hair Loss on Legs/Feet
☐ Loss of Vision	☐ Urinary Incontinence	☐ Sensitive to Sun Exposure
☐ Eye Irritation	☐ Painful Urination	**Neurologic**
☐ Eye Pain	☐ Blood in Urine	☐ Headaches
Ear/Nose/Throat	**Musculoskeletal**	☐ Dizziness
☐ Ringing in Ears	☐ Lower Back Pain	☐ Fainting/Loss of Consciousness
☐ Loss of Hearing	☐ Foot Pain	☐ Numbness/Tingling/Burning ☐ Where? _____
☐ Sore Throat	☐ Leg Pain	☐ Muscle Spasm
☐ Hoarseness	☐ Joint Pain	**Psychiatry**
☐ Difficulty Swallowing	☐ General Muscle Aches/Pain	☐ Anxiety
☐ Nose Bleeds	☐ Swelling in Legs	☐ Depression
Cardiovascular	☐ Joint Swelling	☐ Stress
☐ Chest pain	☐ Joint Stiffness	**Hematology/Oncology**
☐ Palpitations (racing heart/skipped beats)	☐ Change in Gait	☐ Anemia
☐ Fainting	☐ Loss of Leg Strength	☐ Clots
☐ Foot and Leg Swelling	☐ Difficulty Climbing Stairs	☐ Bleeding Problems
Respiratory	☐ Uneven Shoe wear	☐ Easy Bruising
☐ Cough	**Endocrine**	☐ Swollen Glands
☐ Shortness of Breath	☐ Excessive Thirst	**Immunologic/Allergic**
☐ Wheezing	☐ Change in Appetite	☐ Healing Issues
☐ Loud Snoring/Stop Breathing When Asleep	☐ Feeling Too Cold/Hot	☐ Reactions to Dyes, Food, or Drugs

Other/Notes:

_____

_____

_____

FINANCIAL POLICY

Welcome to StepWell Institute for Foot & Ankle Health and thank you for selecting our practice. We are committed to providing you with high quality care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

- Your insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for all services. We cannot guarantee payment of your claims that we file. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Unfortunately, delays in reimbursement may make you subject to a $5.00 per month fee for balances older than 30 days plus a 10% administrative fee. Additionally, you will be charged a service fee of $25.00 for a returned-check due to insufficient funds.

- We participate in several health insurance plans, including Medicare. If you have insurance coverage with a plan that we do not participate with, all charges for your care and treatment are due at the time of service. We will then prepare you a detailed receipt that you have the option to forward to your insurance carrier. All patients are required to pay their co-pay, co-insurance, deductibles, and any patient balances owed of all visits, at the time of their visit. All health 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 an authorization, you will be responsible for the entire charge for all services rendered. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits before services rendered. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency and may provide protected health information to that agency. If such an agency is used, 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 this office.

- In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

- HMO patients must present a valid referral/authorization from their primary care physicians at check in.

- SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

- In order for us to service your account and/or to collect any amounts you may owe, we, SFAS may contact you via phone, text, or email that you have provided.

Signature: _____ Date: _____

Name/relationship of the responsible party (if not patient): _____

Patient's Authorization and Assignment of Benefits:

I hereby authorize the processing of my medical insurance either by electronic or manual method by StepWell Institute for Foot & Ankle Health. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered at StepWell Institute for Foot & Ankle Health. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claims. I grant permission to contact me via email/text/call. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, by me, at any time, in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature: _____ Date: _____

Name/relationship of the responsible party (if not patient): _____

Consent for Treatment:

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize StepWell Institute for Foot & Ankle Health to obtain my medication history from other physicians and/or pharmacies for the purpose of ongoing treatment. I give permission to StepWell Institute for Foot & Ankle Health to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet, ankles, and lower legs.

Signature: _____ Date: _____

Name/relationship of the responsible party (if not patient): _____

Consent to Photograph/Video:

I authorize the doctor or assistants to photograph/video the site of the treatment. Details of the photographing/ videotaping have been explained to me in terms I understand. I understand that the photos or videos are the property of StepWell Institute for Foot & Ankle Health and I may obtain a copy upon my written request. I agree and authorize the use of the photos or videos for teaching purposes, which includes being shown to other patients, in advertisements for StepWell Institute, or to place my photo and/or video on StepWell Institute for Foot & Ankle Health's professional website. I am aware that my name and identity will not be disclosed. An identification photograph will also be taken to be maintained in the medical record.

I **deny consent** to use my photo/video by initialing here: _____

ACKNOLODGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices (NPP), which provides information about how we may use and disclose protected health information about you. By signing this receipt, you acknowledge that you have reviewed, or have been given the opportunity to review, our NPP.

Patient/Representative Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other:

_____

_____

_____