Patient Information Form

Today's Date: ______/ ______/____________

Name:____ **Date of Birth:** ____/_____/_________

(First) (Mi) (Last)

Sex: ☐M ☐ F **Marital Status:** ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Race:_________________ **Primary Language Spoken:** _______________ **Social Security Number:** ______-_____-_________

Home Address: ____ **City/State:** _________________________ **Zip:** ___________

Home Phone No: (__________) ____________-__________________ **Cell Phone No:** (__________) ___________-____________

Work Phone No: (__________) ___________-__________________ **E-Mail:** ____

Emergency Contact: ______________________________**Relationship:** __________________ **Phone:** (_____) ______-_____________

Who is responsible for payment (if other than yourself): ______________________________ **Relationship:** ______________________

Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No

If Yes, Name: ________________________________ **Relationship:** ______________________ **Phone:** (_____) ______-_____________

How were you referred? ☐INSURANCE ☐INTERNET ☐RELATIVE/FRIEND ☐PATIENT ☐ OTHER ____________

Primary Care Information

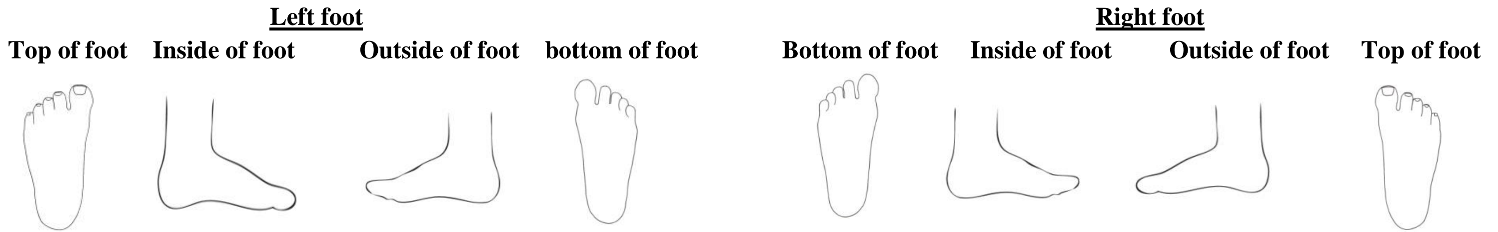
Primary Care Physician: ____

Clinic name: ____ **City/Location:** ____

Pharmacy: ____**City/Location:**____

What specific problem brings you to our office today? ____

Where is the pain/problem located? Please mark on the diagram below.



How long ago did this problem start? ________________ Work injury? ☐No ☐Yes (describe)________________________

How would you rate your pain on a scale from 0 (no pain) to 10(worst pain possible)? ______

Medical History

ALLERGIES:

☐No known drug allergies ☐I have the following drug allergies: ____

Have you ever had any of the following? Check all that apply

☐Abnormal Bleeding	☐Cancer	☐Kidney Disease	☐Pneumonia
☐Acid Reflux	☐Diabetes	☐Liver Disease	☐Polio
☐Anemia	☐Glaucoma	☐Low Blood Pressure	☐Rheumatic Fever
☐Arthritis	☐Gout	☐Migraine Headaches	☐Skin Disorder
☐Asthma	☐Heart Attack	☐Mitral Valve Prolapse	☐Sleep Apnea
☐Back Trouble	☐Heart Disease/ Failure	☐Nerve Disorder	☐Stomach Ulcers
☐Blood Clots	☐Hepatitis / HIV	☐Neuropathy	☐Stroke
☐Blood Transfusions	☐High Blood Pressure	☐Osteoporosis	☐Thyroid Disease
☐Bronchitis/Emphysema	☐Immunosuppressed	☐Other:_____________________	☐Tuberculosis

PLEASE LIST ALL SURGERIES: ____

CURRENT MEDICATIONS: (*If you have a list of medications, please present it to front desk for copying)*

Name	Dose	Name	Dose

Social and Family History

Do you use of alcohol? ☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily ☐History of alcohol abuse

Do you use tobacco? ☐ No ☐ Yes ☐Quit – how long ago? ______________

If yes, are you in a smoking cessation program? ☐ No ☐ Yes

If you use tobacco and are not in a cessation program, why not? ____

Do you have a Living Will or Advanced Health Care Directive? ☐ No ☐ Yes

If no, why not? *Do not wish to* *Not yet* *Other:* ____

Have you received a pneumonia vaccine? ☐ No ☐ Yes When? ____

Have you received the influenza vaccine this season (Sept 2017-March 2018?) ☐ No ☐ Yes

If no, why not? *Do not wish to* *Not yet* *Other:* ____

Do you exercise? ☐Never ☐Rare ☐Occasional ☐Weekly ☐Several times a week ☐Daily

Family History

☐Diabetes ☐Cancer ☐Heart Disease ☐High Blood Pressure ☐Coronary Artery Disease

☐Stroke ☐Rheumatoid Arthritis ☐Thyroid Disease ☐Other ____

ON-SITE PODIATRY dba PINNACLE FOOT AND ANKLE CLINICS

PATIENT FINANCIAL POLICY

Your understanding our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff.

As a patient of Pinnacle Foot and Ankle Clinics, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services at Pinnacle Foot and Ankle Clinics, is due at the time of service. We accept Visa, MasterCard, Discover, cash or check.

Your health insurance policy(s) is a contract between you and your insurance company(s). 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 does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of the service.

If you have insurance coverage with a plan we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means the claim may be denied if out-of-network. Therefore, you are responsible for all charges of your care and treatment.

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 "ineligible for coverage" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarifications of benefits prior to services rendered.

You must inform Pinnacle Foot and Ankle Clinics of all insurance changes and authorization/referral requirements. In the event Pinnacle Foot and Ankle Clinics are not informed, you will be responsible for any charges denied.

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 this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

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.

Print Name of Patient or Parent/Legal Guardian **If other than patient, relationship to patient**

Signature **Date**

Privacy Practices Acknowledgement

I acknowledge that I have received a copy and/or have been made aware of Pinnacle Foot and Ankle Clinics' Privacy Practices.

I also understand that a copy will be provided to me if I so request.

Print Name of Patient or Parent/Legal Guardian

Signature **Date**