Welcome to Advanced Foot Clinics

PATIENT INFORMATION

Date ______________________

Patient ______________________

Address ______________________

____
CITY STATE ZIP

Sex: ☐ M ☐ F Age _____ Birthdate __________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient SS# ______________________

Occupation ______________________

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Spouse's Name ______________________

Spouse's Employer ______________________

Spouse's Occupation ______________________

Whom may we thank for referring you? ______________________

____

PHONE NUMBERS

Home __________ Work __________ ext _____

IN CASE OF EMERGENCY, CONTACT:

Name __________ Relationship __________

Home phone ______________________

Work phone __________ ext _____

INSURANCE

Who is responsible for this account? __________

SS# __________ Relationship to patient __________

Address ______________________

Home Phone __________ Work Phone __________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________

Birthdate __________ SS# __________

Relationship to patient ______________________

Insurance Co. ______________________

Group # ______________________

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

____

____

____

How long? ______________________

Have you ever been to a Podiatrist before? ☐ Yes ☐ No
If yes, please list:

Name __________ Last visit __________

Name __________ Last visit __________

Weight ________ Height ________ Shoe size ________

Please indicate which foot problems you now have or have had in the past:

Problem		
Ankle pain	☐ Yes	☐ No
Ankle sprains	☐ Yes	☐ No
Athlete's foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and calluses	☐ Yes	☐ No
Flat feet	☐ Yes	☐ No
Foot or leg cramps	☐ Yes	☐ No
Hammertoes	☐ Yes	☐ No
Heel pain	☐ Yes	☐ No
Ingrown toenails	☐ Yes	☐ No
Numbness/tingling in feet or legs	☐ Yes	☐ No
Plantar warts	☐ Yes	☐ No
Surgery, foot or ankle	☐ Yes	☐ No
Swelling in ankles or feet	☐ Yes	☐ No
Ulcers, foot or ankle	☐ Yes	☐ No

SOCIAL HISTORY

Alcohol Usage: ☐ Yes ☐ No ☐ Previous use
☐ 1-2/week ☐ 1-2/day ☐ more than 2/day

Cigarette/Tobacco Usage: ☐ Yes ☐ No ☐ Previous use

No. of years of tobacco use: ________
☐ Less than 1 pack/day ☐ 1 pack/day ☐ More than 1 pack/day

OVER

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back problems	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
insulin dependent	☐ Yes	☐ No
non-insulin dependent	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Gastrointestinal disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Hepatitis or jaundice	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Hormone replacement	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Neurological disorder	☐ Yes	☐ No
Psychiatric care	☐ Yes	☐ No
Respiratory disease	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Skin disease/rash	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No

Surgeries you have had ______________________________

____

Hospitalization other than for surgeries listed ______________________________

____

Family physician ______________________________ Last visit date ______________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain ______________________________

FAMILY HISTORY

	Living	Deceased	Cause of death
MOTHER	______	______	______________________
FATHER	______	______	______________________
BROTHER	______	______	______________________
SISTER	______	______	______________________

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins ______________________________

____

____

____

Pharmacy name(s) ______________________________

Pharmacy phone(s) ______________________________

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

- ☐ Adhesive/tape
- ☐ Anticoagulant therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Ibuprofen
- ☐ Morphine
- ☐ Iodine
- ☐ Local anesthesia (Lidocaine, Novocaine)
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ None

Other ______________________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

Patient's / Guardian Signature ______________________________ Date ______________

About FINANCIAL ARRANGEMENTS and INSURANCE

We would like to thank your for choosing our office for your foot care. We will try to make the overall experience as pleasant as possible. We're committed to developing and maintaining excellent relationships with our patients and referring doctors.

If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been made in advance with our staff. We accept cash, checks, Mastercard, Visa or Discover Card. There will be a $25.00 service fee for all returned checks.

CONCERNING INSURANCE

Your insurance is a contract between you and your insurance company. We will be happy to file for you, to obtain pre-treatment estimates, and to be as helpful as we can to help you obtain insurance payment. However, it is **your responsibility** to see that our fees are paid in full. After 90 days it will become the patient's responsibility. Almost no insurance company pays 100% of professional fees. The amount your insurance pays is based on the **policy** you bought and the amount of **premium** you pay. It is not based on our fees.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Pirotta all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE ______________________________

RELATIONSHIP ______________________________ DATE ____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Pirotta for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE ______________________________ DATE ____________

OVER

NON-COVERED SERVICES

Insurance companies (private and government) along with Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862 (A1) of the Medicare law. If your insurance determines that a particular service is "not reasonable and necessary" under Medicare or your insurance company standards, they will deny payment for that service. We believe that in your case, Medicare or your insurance company is likely to deny payment for: trimming of nails, calluses and/or corns, ultrasound therapy, taping, padding, injectables, sterile surgical supplies, and orthopedic appliances for the following reason(s):

It may be considered routine foot care – a non-covered service.
When a patient presents for routine foot care they are responsible for the charge for this service. In addition to this charge there will be a new patient office visit filed with your insurance company. We are required by insurance guidelines to charge for the initial office visit in conjunction with the routine foot care charge. After the initial visit, you would be charged only for routine foot care. However, if on the same day that you have your nails trimmed you have another foot problem not related to your nails, this could result in an office visit for that day.

They simply do not cover that service.

I have been notified by my physician that he or she believes that in my case, Medicare and/or my insurance company is likely to deny payment for the services identified above, for the reasons stated. If Medicare and/or my insurance company denies payment, I agree to be personally and fully responsible for payment.

SIGNATURE ______________________________ DATE ____________