ORTHOTICS, SHOES, AND FOOTCARE

101 Creekside Crossing - Suite 1500
Brentwood, TN. 37027

Podiatry Office of
Dr. David J. Sables

(615) 370-3000 | (615) 370-3331 fax

www.archmasterstn.com

To Our New Patient:

Welcome to ArchMasters! We are thrilled you have chosen us for your foot and ankle needs. We will do our best to provide you with the most utmost professionalism and comprehensive Podiatric care available. We are passionate about foot health and are committed to keeping your feet healthy and happy.

To maximize your time with Dr. David Sables, we ask that you bring the following to your first visit: Photo identification, written referral (if applicable), prior medical records and x-rays (if applicable), and new patient forms (located in this package (if you haven't already submitted them to us)).

Please complete and sign the New Patient Forms included with this letter. These include our Patient Registration, Comprehensive Health Review (include all current medications and dosages), and Consent to Treat.

Whether you have a serious foot or ankle condition or you're simply looking for relief for common foot ailments, ArchMasters is your one-stop-shop for quality Podiatric care and custom orthotics as well as footwear and other foot health products. For your convenience, we offer an on-site shoe store at our office. We look forward to meeting you.

Sincerely,

Dr. David J. Sables

PS – Please visit us online at **www.archmasterstn.com** for additional patient information and our Notice of Privacy Policies.

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PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)		Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Spouse's Name
Street Address		Social Security #		Home Phone # ( )
City	State Zip Code	E-Mail		Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )
Pharmacy Name & Phone #		Primary Care Physician (PCP)		Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill		Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other
Street Address		Social Security #		Home Phone # ( )
City	State Zip Code	E-Mail		Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ❑ Dr. _____ ❑ Hospital/ER ❑ Lecture ❑ Insurance Plan

❑ Phonebook ❑ Internet ❑ Website ❑ Friend/Family: _____ ❑ Other: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Staff Initials: _____

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

Which foot/ankle is involved? ❑ Right ❑ Left ❑ Both

First visit to a doctor for this problem? ❑ Yes ❑ No

Have you had a similar problem in the past? ❑ Yes ❑ No

How was the problem onset? ❑ Sudden ❑ Gradual

The problem is: ❑ Improving ❑ Worsening ❑ Unchanged

The problem is worst: ❑ AM ❑ PM ❑ At Rest ❑ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? ❑ Yes ❑ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Throbbing ❑ Cramping ❑ Itching ❑ Popping

❑ Burning ❑ Tingling ❑ Clicking ❑ Shooting ❑ Stabbing ❑ Other: _____

Describe previous treatments: _____

Is this from an injury? ❑ Yes ❑ No If so, is it work-related? ❑ Yes ❑ No _____

PAST MEDICAL HISTORY

❑ Diabetes Type 1 2 Duration ____ years Last Blood Sugar _____ HbA1c ____

❑ Acid Reflux

❑ Anemia

❑ Anesthesia Complications

❑ Arthritis (❑ Osteo / ❑ Rheum)

❑ Asthma

❑ Back Problems/Sciatica

❑ Blood Clot/DVT

❑ Cancer: _____

❑ Cellulitis/Skin Infection (❑ MRSA?)

❑ Circulation Problem

❑ Dementia/Alzheimer's

❑ Excessive/Easy Bleeding

❑ Fibromyalgia

❑ Foot/Leg Ulcer

❑ Gout

❑ Healing Problems/Keloids

❑ Heart Disease/Heart Attack

❑ High Blood Pressure (❑ Low BP?)

❑ High Cholesterol

❑ Hormone Therapy

❑ Immune Disorder/HIV

❑ Kidney Disease (❑ Dialysis)

❑ Liver Disease (❑ Hepatitis)

❑ Leg Cramps/Leg Pain at Rest

❑ Lung Condition: _____

❑ Mitral Valve Prolapse/Murmur

❑ Multiple Sclerosis

❑ Nervous Disorder/Depression

❑ Neuropathy

❑ Osteomyelitis/Bone Infection

❑ Parkinson's Disease

❑ Previous Addiction to: _____

❑ Pulmonary Embolism

❑ Rashes/Skin Condition

❑ Raynauds Disease/Phenomena

❑ Seizure Disorder/Epilepsy

❑ Sickle Cell Disease/Trait

❑ Sleep Apnea

❑ Stomach Ulcers

❑ Stroke ❑ Rt ❑ Lt (year _____)

❑ Thyroid Condition (❑ Hi ❑ Lo)

❑ Varicose Veins

❑ Women – Are You Pregnant or Breast Feeding?

❑ Other problems not listed: _____

PAST SURGERIES

❑ Foot/Ankle Surgery: _____

❑ Joint Replacement: _____

❑ Open Heart/Bypass Surgery

❑ Hysterectomy ❑ Tubal ligation ❑ C-Section

❑ Stent Placement: Heart Leg

❑ Cosmetic Surgery: _____

❑ Appendix ❑ Gallbladder ❑ Tonsils/Add

❑ Leg Bypass ❑ Open Fracture Repair

❑ Carotid Surgery ❑ Vein Surgery

❑ Hernia repair ❑ Thyroid ❑ Back surgery

❑ Other: _____

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

❑ Cancer	M F S B GP
❑ Diabetes	M F S B GP
❑ Gout	M F S B GP
❑ Heart Disease	M F S B GP
❑ High Blood Pressure	M F S B GP
❑ Severe Arthritis	M F S B GP
❑ Anesthesia Complications	M F S B GP
❑ Foot Problems	M F S B GP
❑ Other: _____	M F S B GP

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ❑ **None**
- ❑ Adhesives/Tape
- ❑ Aspirin
- ❑ Codeine
- ❑ Cortisone
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Seafood/Shellfish
- ❑ Sulfa Drugs
- ❑ _____

SOCIAL HISTORY

Occupation: _____

❑ I Drink Alcoholic Beverages How much/often? _____

❑ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

❑ I Use or Have Used Drugs that are Illegal _____

I Live With: ❑ No One ❑ Spouse ❑ Children ❑ Parents ❑ Other

I Stand _____ % of My Day

I Exercise Each Week: ❑ 0 days ❑ 1-2 days ❑ 3+ days

List Sports/Activities: _____

❑ My foot/ankle problem limits my activities

I am: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ❑ Recent Weight Changes
- ❑ Fever/Chills
- ❑ Nausea or Vomiting
- ❑ Fatigue

EYES
- ❑ Eye Disease/Injury
- ❑ Wear Glasses/Contacts
- ❑ Blurred or Double vision
- ❑ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ❑ Hearing Loss
- ❑ Nose Bleeds
- ❑ Sore Throat/Voice Change
- ❑ Sinus Problems
- ❑ Difficulty Swallowing

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Arrhythmia/Irregular Heart Beat
- ❑ Leg Pain when Walking
- ❑ Swelling of Hands/Feet

MUSCULOSKELETAL
- ❑ Muscle Pain or Cramps
- ❑ Joint Pain
- ❑ Stiffness/Swelling Joints
- ❑ Low Back Pain
- ❑ Trouble Walking

GASTROINTESTINAL
- ❑ Indigestion/Heartburn
- ❑ Diarrhea
- ❑ Blood in Stools
- ❑ Stomach Pains

RESPIRATORY
- ❑ Shortness of Breath
- ❑ Chronic/Frequent Cough
- ❑ Wheezing

GENITOURINARY
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Kidney Stones
- ❑ Blood in Urine

INTEGUMENTARY
- ❑ Rash or Itching
- ❑ Dry Skin
- ❑ Change in Hair/Nails

HEMATOLOGICAL
- ❑ Bruise Easily
- ❑ Slow to Heal

ENDOCRINE
- ❑ Hormonal Problem
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Too Hot/Too Cold

NEUROLOGICAL
- ❑ Migraines
- ❑ Frequent Headaches
- ❑ Numbness/Tingling
- ❑ Dizzy Spells
- ❑ Paralysis/Tremors

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Nervousness
- ❑ Insomnia
- ❑ Confusion/Memory Loss

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

For Office Staff BMI _____

BP _____ P _____ O2 Sat _____ Temp _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Staff Initials: _____

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FINANCIAL POLICY

1. SELF PAY: All payments are due at the time of visit or time products/service was provided (or please ask us about payment plans available). Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards. You are ultimately responsible for payment of charges for services you receive from our office.
2. If you require a referral, it is your responsibility to obtain this prior to being seen by our provider.
3. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.
4. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $25.00 No Show Fee.
5. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Tennessee. Fees must be received prior to record delivery. No more than 5 pages may be faxed.
6. Administrative Services: There is a $25.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance.
7. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.
8. While we do not bill insurance companies. We encourage you to submit your receipt of services/ products rendered to your insurance company, as some insurance companies may reimburse you for Podiatry services and medical device (custom orthotics, therapeutic footwear). We can provide a letter of services provided if requested by your insurance company.

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CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the ArchMasters Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize ArchMasters to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the ArchMasters Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: _____

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize ArchMasters to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at ArchMasters and it may include prescriptions back in time for several years.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by ArchMasters Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the ArchMasters Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions.

Patient Initials: _____

ArchMasters may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of you obtaining payment for services and determining your insurance benefits or the benefits payable for related services.

DISCLOSURE OF SERVICES

During my course of treatment, products and/or services from related businesses may be recommended. I understand that I am under no obligation to patron these businesses and that I may find alternate sources to purchase these products and/or services.

Patient Initials: _____

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a ArchMasters patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date	Staff Initials: ____

ArchMasters - Orthotics, Shoes & Footcare
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Brentwood, TN. 37027
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www.archmasterstn.com

HIPAA Notice of Privacy Practices
Written Acknowledgement Form

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose medical information about you.

I, _____ *(print patient name)*, with the date of birth _____ *(print patient date of birth)* have been provided access to a copy of the ArchMasters NPP for review.

This acknowledgement form will be in effect until otherwise revoked by me in writing.

I hereby consent to the release of any/all information regarding my medical history, current medical condition, current medical treatment and any/all patient account information to the individual(s) listed below: ***(If you would not like any information to be released please leave blank).***

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date