TOWN CENTER
PODIATRY, PLLC

New Patient Packet

Today's Date_____

Name_____Date of Birth _____-_____-_____

Billing Address_____

Social Security # xxx-xx-_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: _____ Ethnicity: _____

Home Phone (____) _____ -_____ Cell Phone (_____)_____-_____

Email_____

Employer_____ Occupation _____

Primary Physician:_____Date last seen: _____

Pharmacy Name/Number _____

I, Authorize the release of any medical information necessary to process my insurance and I also authorize my insurance company to make payment of any medical benefits to the provider for services.

I understand that I am financially responsible for my medical care and my insurance will be filled as a courtesy.

HIPPA: Please list who we may communicate with regarding your private health information.

Name: _____ Phone: _____

Relationship to you:_____

Patient Signature: _____Date:_____

REASON FOR TODAY'S VISIT: PLEASE INDICATE THE PROBLEM

What is the main foot or ankle problem:

_____

Do you have any other Foot or ankle complaints:

_____

HISTORY OF PRESENT ILLNESS: BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

When did your problem begin?

_____

Location of the problem:

_____

Is the pain: □ Burning □ Throbbing □ Sharp □ Dull □ Aching □ Other: _____

What causes the problem or makes it worse?

_____

Was it caused by an injury? □ No □ Yes

Have you treated or had anyone else treat this problem? □ No □ Yes

PAST MEDICAL HISTORY:

Height: _____Ft. _____in. Weight _____lbs. Shoe size _____

Major Illnesses: □ No serious past illnesses □ Diabetes □ Arthritis □ Heart Disease □ Hypertension □ Cancer: _____

□ HIV□ Hepatitis □ High Cholesterol □ Kidney disease □ Dialysis □ Asthma Other: _____

Surgeries & Hospitalization: □ None □ List: _____

_____

Medications: Prescriptions: _____

_____

ALLERGY: □ Latex □ Adhesive tape □ Aspirin □ Codeine □ Iodine □ Sulfa □ Morphine □ Local Anesthetics

□ Penicillin □ Seafood Reaction Other: _____ Type: □ Rash □ Trouble Breathing

□ No Known Drug Allergy

FAMILY HISTORY:

Mother: □ High cholesterol □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Father: □ High Cholesterol □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Sibling: □ High Cholesterol High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

SOCIAL HISTORY: Use of: □ Tobacco Pack/Day_____ □ Alcohol How much per/day_____ □ Illicit Drugs_____

Patient Signature: _____Date:_____

General: □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping

Skin: □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes

Ears: □ Decreased hearing □ Ringing in ears □ Earache □ Drainage

Eyes: □ Vision □ Glasses or contacts □ Redness □ Blurry or double vision □Glaucoma □Cataracts

Nose:- □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus

Throat: □ Teeth □ Dry mouth □ Sore throat □ Swollen glands □ Pain □ Stiffness

Respiratory: □ Cough □ Shortness of breath □ Shortness of breath with activity □ Swelling (edema)

Gastrointestinal: □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)

Urinary: □ Frequency □ Urgency □ Burning or pain □ Blood in urine □ Incontinence

Vascular: □ Calf pain with walking (Claudication) □ Leg cramping

Musculoskeletal: □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma

Neurologic: □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling

Hematologic: □ Ease of bruising □ Ease of bleeding

Endocrine: □ Heat or cold intolerance □ Sweating □ Frequent urination □ Thirst

Psychiatric: □ Nervousness □ Depression □ Memory loss □ Stress

Patient Signature: _____Date:_____

How were you referred to our office?

____Online ____ Friend____Family____Physician_____OTHER_____

Financial, Release of Records & Receipt of Privacy Policy Agreement and Acknowledgement

- **Insurance co-pays are due at the time of your appointment**. Your insurance policies may require you to make a copayment or pay a deductible for an office visit, a diagnostic test, and/or a procedure; therefore payment is expected on the date of service.
- Our office accepts many health care plans. We will bill those plans with which we have an agreement and collect co-pays at the time of service. In the event that your insurer determines the service is "not covered" by the terms of your health care plan, you will be responsible for payment in full on the date of service(s) including office visits and procedures.
- In the event that our physician(s) are not enrolled with your health care plan, you will be responsible for payment in full on the date of service(s). In this instance, you may submit your claim directly to your carrier to request reimbursement.
- In the event that your medical expenses will not be submitted to an insurance carrier, payment is due at the time of service including office visits and procedures.
- **Many insurance companies require authorization for visits to receive full benefit coverage**. If you are unsure if authorization is required, please call your insurance carrier directly. If required, the authorization must be received before your visit. Failure to provide us with the proper authorization may result in the rescheduling and/or cancellation of your appointment.
- Form fees are not covered by your insurance company. Therefore, there will be a $10.00 charge for each form. This is to be paid in advance.

Financial Agreement

- I hereby assume full responsibility for all charges incurred for professional services rendered by Town Center Podiatry, PLLC, and its assistants, including collection costs, unless the services are deemed "paid in full" as a result of a contractual agreement between Town Center Podiatry, PLLC and my insurer.

Authorization for the Release of Information

- I hereby authorize Town Center Podiatry, PLLC to release any medical information to my referring physician and any insurance company with whom I have medical benefits for filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

Group & Individual Insurance, Assignment of Benefits

- I authorize my health insurance benefit plan to pay directly to Town Center Podiatry, PLLC the medical and/or surgical, if any, otherwise payable to me for their services as described on the attached claim but not to exceed the charges for those services. I understand I am financially responsible to Town Center Podiatry, PLLC for charges not covered by this assignment.

Medicare, Claim Authorization and Payment Request

- I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or to the party who accepts this assignment. Regulations of Medicare assignment of benefits apply.
    - I acknowledge that I have read and agree to the financial policy of Town Center Podiatry, PLLC.
    - I acknowledge that I have read and agree to the privacy policy of Town Center Podiatry, PLLC.

Acknowledgment of Receipt of Privacy Practices.

- I acknowledge that a copy of the Privacy Practice will be made available to me at my request and that I have read (or had the opportunity to read if so chose) and understood the Notice.

Signature of Patient/Responsible Party: _____

Print Name: _____ Date: _____ / _____ / _____