Patient Information

Patient Information

Patient Name: ____________________ DOB: ____________ Sex: ______

Driver's License: ____________________ SSN: ____________

Home Phone: ____________________ Cell: ____________

Address: ____

Employer: ____________________ Position: ____________

Employer Address: ____________________ Phone No. ____________

Emergency Contact Information

Dependent? __________ If yes, Guardian's Name: ____________

Guardian's Phone: ____________________ Cell: ____________

Marital Status: ____________________ Spouse's Name: ____________

Spouse's Employer: ____________________ Work Phone No. ____________

Emergency Contact: ____________________ Relationship: ____________

Home Phone: ____________________ Cell: ____________

Emergency Contact: ____________________ Relationship: ____________

Home Phone: ____________________ Cell: ____________

Insurance

Insured Party: ____________________ Relationship to Patient: ____________

Insurance Company: ____________________ Phone No. ____________

Address: ____

Policy No. ____________________ Group No. ____________

Dual Coverage? __________ 2nd Insurance Company: ____________

Insured Party: ____________________ Relationship to Patient: ____________

Phone No. ____________________ Address: ____________

Policy No. ____________________ Group No. ____________

Payment Method: ____________________ Card/Check No. ____________

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

______________________________ ____________________

Patient Date

MY MEDICATION LIST

Patient Name: ______________________ Date: ____________________

Date of Birth: ______________________

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointment.***

Drug Name	Drug Strength	Amount and Times of Day Taken	Reason for Medication	Prescriber

Do you have any allergies? _____ Yes _____No

If yes, please list:

____

____

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

☐ OTHER ______________________________

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ______________________________
☐ ANESTHESIA ______________________ ☐ FOODS ______________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Condition			Condition			Condition		
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

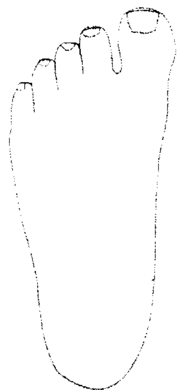
OTHER CONDITIONS:

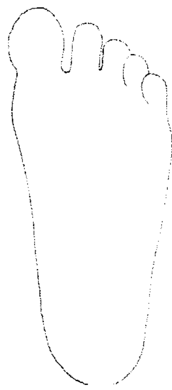
CURRENT PROBLEM

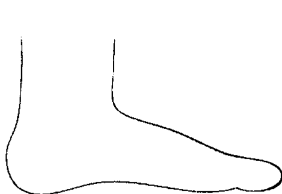
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

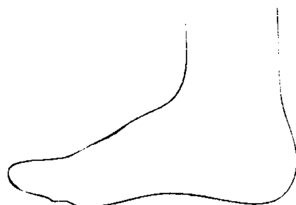
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT


TOP OF FOOT

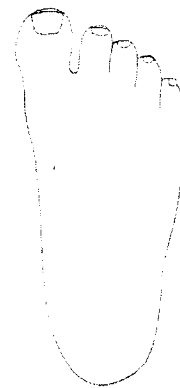

BOTTOM OF FOOT

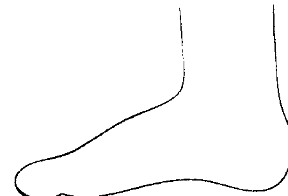




RIGHT FOOT

BOTTOM OF FOOT


TOP OF FOOT



PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ TYPE ______________
☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ______________________ OCCUPATION: ______________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? ______
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER ______________________

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ______________________________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS

Revised June 2015

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

INSIDE OF FOOT | OUTSIDE OF FOOT | OUTSIDE OF FOOT | INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ______________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ OTHER ______________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

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, PARENT OR GUARDIAN

____
SIGNATURE OF DOCTOR

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
DATE

____
SIGNATURE

____
DATE

Patient Financial Policy

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

- As our patient, 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 office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. 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.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 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 clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- 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.

Signature of Patient/Responsible Party: ______________________________

Printed Name of Patient/Responsible Party ______________________________ Date: __________

________ Patient initials to indicate copy received.

Janice S Albritton, DPM
Alvo O Albritton, DPM

SIGNATURE ON FILE

_I authorize use of this form on all my insurance submissions.
_I authorize release of information to all my insurance companies.
_I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
_I authorize payment directly to my doctor.
_I understand I am responsible for my bill
_I permit a copy of this authorization to be used in place of the original

____
Patient or Insured's name (printed)

____________________________ Date___________
Signature

___________________________________ Date___________
Parent/guardian/Power of attorney (if necessary)