Dr. Eric J. Plumley DPM

Today's Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Date Of Birth: ___/___/_____ Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Address: _____ City: _____ State: _____Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

Marital Status: _____ Spouse Name: _____ # Of Children: _____

Emergency Contact: _____ Phone Number: _____

SS#: _____

Reason For Visit Today: _____

Allergies- Please circle if you have ever had any adverse reactions or side effects to any of the following:

Penicillin Local Anesthesia Adhesive Tape Codeine Iodine Latex Metal/ Jewelry

No Known Allergies Other: _____

Medications And Dosages: Please give us a detailed list of all medications and their dosages, if you have a medication list with you, you can give that to our receptionist.

_____

_____

_____

Do you smoke: YES NO If yes: How long? _____ Packs Per Day____ If quit- How long ago: _____

Do you drink Alcohol: YES NO If yes: How many drinks per week? _____ If quit- When: _____

Dr. Eric J. Plumley DPM

MEDICAL INFORMATION

Previous Surgeries And Dates: _____

_____

Have You Ever Had A Problem With Any Of The Following: PLEASE CIRCLE

Recent Fever Weight Change Eyes Ears Nose Throat Heart Circulation Blood Pressure High Liver

Blood Pressure Low Arthritis Gout Cancer Skin Ulcers Rashes Back Pain Hip Pain Knee Pain Anemia

Diabetes (If yes: Type _____) Thyroid Steroid Use Psychiatric Disorders Bleeding Bruising Clotting

Lungs Asthma Seizures Kidneys Bladder Stomach Immune Disorders

Other: _____

Health Issues That Run In The Family: PLEASE CIRCLE

Diabetes Heart And Circulation Problems Other: _____

Preferred Pharmacy : _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Please Sign Below Acknowledging That All Information Is Accurate

Print Name: _____

Signature Of Patient Or Guardian :_____ Date: _____

Dr. Eric J. Plumley DPM

Financial Policy

WE ARE COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY MEDICAL AND SURGICAL CARE. IN RETURN WE ASK YOU TO BE EQUALLY COMMITTED TO BEING FULLY RESPONSIBLE FOR PAYING OUR FEES. THIS WILL HELP IN REDUCING OUR BILLING AND ADMINISTRATIVE BURDENS, LEAVING MORE TIME FOR HELPING YOU. THIS DUAL COMMITMENT IS THE FOUNDATION OF OUR RELATIONSHIP. OUR GOAL IS TO MAXIMIZE THE QUALITY OF YOUR CARE AND MINIMIZE MISUNDERSTANDINGS REGARDING FEES AND PAYMENTS.

WE ACCEPT MANY DIFFERENT INSURANCE PLANS. HOWEVER, ALL HEALTH PLANS DO NOT COVER THE SAME SERVICES.

MANAGED CARE PATIENTS/ PRIVATE INSURANCE: IF YOU ARE IN A MANAGED CARE PLAN (HMO, PPO, IPA) WITH WHOM WE PARTICIPATE, WE ABIDE TO OUR CONTRACT WITH THEM. IN EITHER MANAGED CARE PLANS OR PRIVATE PLANS, WE WILL BILL YOUR INSURANCE COMPANY; HOWEVER YOU ARE RESPONSIBLE FOR PAYING ANY CO-PAYS REQUIRED BY YOUR PLAN AT THE TIME OF TREATMENT. IN 30-45 DAYS YOUR INSURANCE COMPANY WILL SEND YOU AN EXPLANATION OF BENEFITS (EOB) THAT TELLS YOU WHAT YOUR BALANCE IS, IF ANY, TO OUR OFFICE.

MEDICARE PATIENTS: WE ACCEPT ASSIGNMENT FOR MEDICARE, HOWEVER THAT DOES NOT MEAN THAT ALL SERVICES ARE COVERED. PATIENTS ARE RESPONSIBLE FOR PAYING THEIR ANNUAL DEDUCTIBLE IF IT HAS NOT YET BEEN MET. YOU ARE ALSO RESPONSIBLE FOR ANY CO-PAYMENTS, WHICH ARE USUALLY 20% OF THE ALLOWED AMOUNT FOR AN ITEM OR SERVICE.

UNISURED PATIENTS: PAYMENT IS DUE AT THE TIME OF SERVICE

ALL PATIENTS: FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, AMEX, CASH OR CHECK. THERE IS A SERVICE FEE OF $10.00 FOR ALL RETURNED CHECKS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTOOD THE NOTICE.

DURABLE MEDICAL EQUIPMENT POLICY

IN THE EVENT THAT THE PATIENT LEAVES THE OFFICE WITH AN ITEM RECOMMENDED IN THE CARE AND TREATMENT OF THEIR FOOT CONDITION (INCLUSIVE OF, BUT NOT LIMITED TO, CUSTOM MADE ORTHOSES, ANKLE/FOOT ORTHOSES, NIGHT SPLINTS, WALKING BOOTS, PADS, ETC). IT IS UNDERSTOOD THAT SUCH ITEMS ARE NON-RETURNABLE AND NON-REFUNDABLE. IT IS THE POLICY OF THIS OFFICE TO HELP OBTAIN INSURANCE BENEFITS REGARDING A PATIENTS INDIVIDUAL COVERAGE OF THESE ITEMS BY CONTACTING THEIR INSURANCE COMPANY. THIS IS A COURTESY SERVICE WHICH WE ARE HAPPY TO PROVIDE; HOWEVER ERIC J PLUMLEY DPM IS NOT HELD RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION RECEIVED. INFORMATION RECEIVED BY PHONE IS NOT A GUARANTEE OF PAYMENT AND, IF ANY DOUBTS EXIST TO ELIGIBILITY, IT IS HIGHLY RECOMMENDED THAT YOU CHECK YOUR PLAN BOOKLET FOR A DETAILED OUTLINE OF YOUR BENEFITS OR MAKE A PERSONAL PHONE CALL TO YOUR INSURANCE COMPANY. PLEASE NOTE, IF THESE ITEMS ARE DENIED BY INSURANCE DUE TO COVERAGE LIMITATIONS, THE PATIENT HEREBY ACCEPTS RESPONSIBILITY FOR THE COST.

SIGNATURE ON FILE AND PERMISSION TO TREAT

I REQUEST THAT PAYMENTS OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF OR FOR ANY SERVICES FURNISHED ME BY **ERIC J PLUMLEY DPM.** I AUTHORIZE ANY HOLDER OF INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES TO THE INSURANCE AGENT. I RECOGNIZE MY FINANCIAL OBLIGATION OF ANY CO-INSURANCE, CO-PAYS OR DEDUCTIBLES AND NON-COVERED SERVICES THAT MAY BE REQUIRED. I GIVE PERMISSION TO DR. PLUMLEY AND HIS STAFF TO EVALUATE AND TREAT MY FOOT/ANKLE CONDITION.

SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THE ABOVE SECTIONS FINANCIAL POLICY PRIVACY PRACTICES, DURABLE MEDICAL EQUIPMENT POLICY AND SIGNATURE/ PERMISSION TO TREAT

_____ _____

PRINT NAME **DATE**

_____

SIGNATURE

Dr. Eric J. Plumley DPM

18 YEARS AND OLDER: MIPS

BMI- Current Height: _____ Current Weight: _____
DIABETES: Are you diabetic? YES or NO HgA1C if available: _____
Date of your last diabetic eye exam: _____ Performed by: _____
Date of your last diabetic foot exam: _____Performed by: _____
TOBACCO USE: Do you smoke? YES or NO
BLOOD PRESSURE: Do you have high blood pressure? YES or NO
IMMUNIZATIONS: A. Did you receive the FLU vaccine? YES or NO If YES, date received:
B. Did you receive the Pneumonia Vaccine? (65 years and older) YES or NO If YES, date received:
ADVANCED CARE PLANNING: Do you have a Living Will, DNR or Power of Attorney for healthcare? YES or NO
If YES, name and relation to administrator: _____

50 YEARS AND OLDER: PERIPHERAL ARTERY DISEASE QUESTIONNAIRE

1. **YES or NO** Do you have high cholesterol, or are you on cholesterol medication?
2. **YES or NO** Do you have a history of aortic aneurysm?
3. **YES or NO** Do you have a history of diabetes, high blood pressure or aortic aneurysm?
4. **YES or NO** Have you ever had a stroke, mini-stroke or heart attack?
5. **YES or NO** Do you experience aching. Cramping or pain in your legs, thighs or buttocks when you walk or exercise?
   If **YES**, does the pain improve with rest? YES or NO
6. **YES or NO** Do you experience cramping, tightness, "charlie horses" or pain in the legs or feet when lying down?
   If **YES**, does the pain improve when you stand up? YES or NO
7. **YES or NO** Do you have numbness and tingling in the lower legs and feet?
8. **YES or NO** Are your toes pale, discolored, or bluish?
9. **YES or NO** Are your feet cold to the touch?
10. **YES or NO** Do you have sores or ulcers on your legs or feet that do not heal?

65 YEARS AND OLDER: ARE YOU AT RISK FOR FALLING?

1. **YES (2) OR NO (0)** I have fallen in the past year
2. **YES (2) OR NO (0)** I use or have been advised to use a cane or walker to get around safely
3. **YES (1) OR NO (0)** Sometimes I feel unsteady when I am walking
4. **YES (1) OR NO (0)** I steady myself by holding onto furniture when walking at home
5. **YES (1) OR NO (0)** I am worried about falling
6. **YES (1) OR NO (0)** I need to push with my hands to stand up from a chair
7. **YES (1) OR NO (0)** I have some trouble stepping up onto curbs
8. **YES (1) OR NO (0)** I often have to rush to the toilet
9. **YES (1) OR NO (0)** I have lost some feeling in my feet
10. **YES (1) OR NO (0)** I take medicine that can make me feel light headed or more tired than usual
11. **YES (1) OR NO (0)** I take medicine to help me sleep or improve my mood
12. **YES (1) OR NO (0)** I often feel sad or depressed

Total Points: _____

MA: _____ Doctor: _____ Front: _____

PATIENT EMAIL AND TEXT MESSAGE REGISTRATION FORM

DUE TO THE CHANGING WORLD OF HEALTHCARE AND TECHNOLOGY, ERIC J PLUMLEY DPM NOW HAS THE ABILITY TO PROVIDE OUR PATIENTS WITH CERTAIN TYPES OF INFORMATION VIA EMAIL/ TEXT MESSAGING. IF YOU WISH TO HAVE THE OPPORTUNITY TO RECEIVE INFORMATION OF THIS TYPE, PLEASE COMPLETE THE FORM BELOW.

ERIC J PLUMLEY DPM BELIEVES STRONGLY IN PROTECTING THE PRIVACY OF OUR PATIENTS. WHEN YOU PROVIDE THIS INFORMATION TO US, IT IS ONLY USED AS A WAY TO COMMUNICATE WITH YOU. IN ORDER TO PROTECT YOUR PRIVACY, NO CONFIDENTIAL OR PERSONAL INFORMATION WILL BE SENT FROM ERIC J PLUMLEY DPM VIA EMAIL OR TEXT MESSAGING.

PLEASE MAKE A SELECTION FROM THE FOLLOWING:

- YES, PLEASE SIGN ME UP TO RECEIVE EMAIL AND TEXT MESSAGING CONFIRMATIONS.
- I DO **NOT** WISH TO BE CONTACTED VIA EMAIL (TEXT MESSAGING ONLY)
- I DO **NOT** WISH TO BE CONTACTED VIA TEXT MESSAGING (EMAIL ONLY)
- I DO **NOT** WISH TO BE CONTACTED BY EITHER TEXT MESSAGING OR EMAIL.

I HEREBY GIVE ERIC J PLUM.LEY PERMISSION TO SEND MESSAGES TO ME VIA EMAIL OR TEXT MESSAGING AS MEANS OF COMMUNICATION AS INDICATED BY MY SELECTION ABOVE.

_____ _____

SIGNATURE DATE

HIPPA AUTHORIZATION AND PRIVACY AGREEMENT

PATIENT INFORMATION:

FULL NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____

AUTHORIZED INDIVIDUAL:

FULL NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____

AUTHORIZED PRACTICE:

PRACTICE NAME: _____ ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

I HEREBY GIVE ERIC J PLUMLEY DPM PERMISSION TO COMMUNICATE WITH THE LISTED INDIVIDUALS REGARDING MY HEALTHCARE INFORMATION, APPOINTMENTS, TREATMENT OR BILLING MATTERS. I UNDERSTAND THAT I MAY ALTER THESE SELECTIONS AT ANY TIME.

_____ _____

SIGNATURE DATE