Dr. Spero E. Demoleas, DPM, DABPS

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Dr. Demoleas Welcomes You to Our Office!

Thank you for selecting our office for your foot and ankle health care needs. We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

URGENT INFORMATION ABOUT REFERRALS:
You cannot assume that your referral has been approved unless you have received written confirmation from your insurance company. If you are not sure your referral has been approved, please contact your insurance company prior to your appointment. ***If we do not have a paper copy of the referral in the office you may be financially responsible for the appointment, unless other arrangements are made at the time of service.***

When you come for your appointment, please bring the following:
(Do not send prior to your appointment)

- Written Referral (If required by your insurance company)
- Completed *Patient Registration Form*
- Completed *Medical History Form*
- Completed and Signed *Authorization and Treatment Form*
- Medical Insurance card
- Previous x-rays and medical records, if applicable
- Shoes (bring a sample of the more common shoes you wear - including athletic and walking shoes)

Note: As you will be receiving advice on the proper shoes for your feet, we recommend you do not purchase any new shoes prior to your visit.

Please be prepared to pay for the following at the time of your visit:

- Co-Payment (if applicable)
- If no insurance, the full cost of visit

We accept cash and checks only.

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

Your Scheduled Appointment is ____________________________at ________AM / PM

As a courtesy to other patients who are waiting to get in, please call at least 24 hours in advance if you must cancel your appointment. We reserve the right to charge for missed appointments.

PATIENT REGISTRATION

Patient Information

Patient Name: Last **First** **M.I.** ☐ **M** ☐ **F**

By what name do you preferred to be addressed? **Single Married Widowed Other**

Patient's Address:

City **State** **Zip**

Home Phone: **Work Phone:** **e-mail address**

Social Security #: **Birthdate:** **Age:**

Employer: **Occupation:**

Emergency Contact: **Phone#:**

Would you like to receive quarterly email updates to our list of recommended shoes? □ **Yes** □ **No**
Email addresses are never sold or used for any purpose other than these updates

Insurance

Name of insured (if other than self) **Birth Date:**

Name of insured's employer: **Insured's work phone number:**

Patient is: □ **Subscriber** □ **Spouse** □ **Dependent**

Name of person responsible for paying the bill (the Guarantor):
☐ **Same as patient** ☐ **Same as insured**

Guarantor's Address:

Guarantor's Telephone:

L&I Injury

Date of Injury: **Type of Injury:** □ **Work** □ **Auto** □ **Other**

Has a claim been filed? □ **Yes** □ **No** **Claim#:** **Where was claim filed?**

Cause of injury:

Referral

Referred By:
☐ **Friend / Relative** ☐ **Web search (Google, Yahoo)** ☐ **Yelp** ☐ **Citysearch** ☐ **Online Yellow Pages**
☐ **Insurance Web Site or Book Referral** ☐ **Returning patient of this office** ☐ **Yellow Pages**

☐ **Doctor (name):**____ ☐**MD** ☐**DO** ☐**DC** ☐**ND**

☐ **Other**: ___________________________________

Primary Care Physician and Clinic Name **Phone #:**

Signature

Release of Benefits Information :

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient Signature:_________________________________**Date:**___________________________________

WS

Medical History - Confidential Information

Patient Name________________________

Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?
(Include foot, ankle, leg, knee and hip complaints)

____
____
____
____

Former foot and ankle physician:
Name:____________________________________

Last visit:________________________________

Any previous injuries or problems to the feet, ankles or legs?

____

Symptoms

Which Side: Right Left Both

Type of Pain: Dull Achy Throbbing Burning Sharp Shooting

Area of Pain:__________________________________

Onset: Slow Sudden Traumatic

Duration: ________ Days Weeks Months Years

Has pain gotten: Better Worse Stayed the Same

What aggravates condition? walking running standing shoes

What have you tried to help the pain? Changing shoes anti-inflammatories Decrease activities Arch Supports or Orthotics Ice Stretch

Other:____

How long does pain last?_________________________

Have you ever had a similar pain? (describe, including treatments received)

Exercise and Orthotics

In what athletic activities do you participate ?

____

days per week exercising? _______________________

Do you wear store-bought arch supports? yes no

Do you wear custom orthotics? yes no

If yes, who made them: ________________________

How old are the orthotics: ______________________

Allergies and Drug Intolerance

Adhesive/Tape	Aspirin
Codeine	Iodine
Local Anesthetics	Penicillin
Seafoods	Sulfa
No known drug allergies	_________________

Medications

List all medications you are taking:

____
____
____
____
____
____
____
____
____

General

What is your weight:_______________

What is your height: _______________

What is your shoe size:______________

Mental / Emotional

yes	no	Eating Disorder
yes	no	Anxiety
yes	no	Depression
yes	no	Psychiatric
yes	no	Alcoholism

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

____
____
____
____
____

Social History

Your occupation?

____

Do you smoke? yes no

Are you a past smoker? yes no

How Much?____packs/ _____.
Years Smoked:_________

Drink Alcohol?: yes no
How Much:___________

Recreational Drugs? yes no
What:____________

Pregnant or possibly pregnant? yes no

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family Member
yes	no	Anemia	
yes	no	Arthritis: Type:_________	yes
yes	no	Artificial Heart Valve or Joints	
yes	no	Asthma	yes
yes	no	Back Problems	
yes	no	Bleed easily	yes
yes	no	Cancer	yes
yes	no	Chemical Dependency	yes
yes	no	Chest Pain	yes
yes	no	Circulatory Problems	yes
yes	no	Diabetes	yes
yes	no	Epilepsy	yes
yes	no	Fibromyalgia	
yes	no	Gout	
yes	no	Heart Disease	yes
yes	no	Hemophilia	yes
yes	no	Hepatitis	
yes	no	High Blood Pressure	yes
yes	no	HIV Positive	
yes	no	Kidney Problems	yes
yes	no	Leg Cramps	
yes	no	Liver Disease	yes
yes	no	Lung/Respiratory	yes
yes	no	Menopause	
yes	no	Mental Illness	yes
yes	no	Phlebitis / Clots	yes
yes	no	Psoraisis	yes
yes	no	Rheumatic Fever	
yes	no	Stroke	yes
yes	no	Thyroid Problems	
yes	no	Tuberculosis	
yes	no	Ulcers—Stomach	
yes	no	Venereal Disease	
yes	no	Weight Change, Recent. _____lbs	

Spero E. Demoleas, DPM, DABPS

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, ____________________________________, hereby authorize Dr. Spero E. Demoleas, DPM to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize him to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by him. I request payment from my insurance company or Medicare to be made directly to him. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all of my dependents for any claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. I may revoke this authorization at any time with written notice to Dr. Spero E. Demoleas. Most insurance plans require that patient's authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient cannot sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We cannot call your doctor to request a referral on your behalf. If you have copay, it is due at the time of the visit. If you fail to pay your copay at the time of the visit, a $5.00 surcharge will be applied. We do not bill for copays.

HIPAA "Notice of Privacy Practice"

I hereby acknowledge receiving Dr. Spero E. Demoleas' "Notice of Privacy Practice", which is attached to this page. This is a five-page document, including a "Summary of Notice of Privacy Practices". The full "Notice of Privacy Practice", is posted in the office and on this web site. Additionally, I may ask for and receive a full copy.

MEDICARE PATIENTS ONLY

I request that payment of authorized medical and surgical benefits and supplies be made to Dr. Spero E. Demoleas on my behalf or any covered dependants. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS

As a self-paying patient, I understand that I am responsible for and will pay for all medical/podiatric services up front.

I have read, understand, and agree to the above.

_______/_______/_________
Date

________________________________ Patient's Name (Please Print)

________________________________ Patient's Signature

________________________________ If under 18 years old, Parent's or Guardian's Name

________________________________ If under 18 years old, Parent's or Guardian's Signature