PATIENT INFORMATION

Thank you for selecting Suburban Podiatry, Ltd! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date_____Birthdate_____

Name_____

Wishes to be called _____Soc. Sec. # _____

❑Male ❑Female ❑Minor ❑Single ❑Married

Address_____

City, State, Zip_____

Employer_____Occupation_____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Home Phone_____Work Phone_____

Cell Phone_____Ext._____

Email_____

Where do you prefer to receive calls? ❑Home ❑Work ❑Car

In the event of an emergency, who should we contact?

Name_____Relationship_____

Work #_____Home #_____Cell #_____

INSURANCE INFORMATION

Primary Insurance	***Secondary Insurance***
Name of Insured_____	Name of Insured_____
Relationship to Patient_____	Relationship to Patient_____
Insured's Birthdate_____	Insured's Birthdate_____
Soc. Sec. #_____	Soc. Sec. #_____
Employer_____	Employer_____
Insurance Co._____	Insurance Co._____
Insurance ID#_____	Insurance ID#_____
Insurance Group #_____	Insurance Group #_____
Deductible_____	Deductible_____
Co-pay_____	Co-pay_____

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RESPONSIBLE PARTY

Name_____Relationship to Patient_____

Birthdate_____ Soc. Sec. #_____

Address_____

Home Phone_____Work Phone_____

Driver's License #_____

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I also give permission for x-rays to be taken if necessary.

I understand and agree that health and accident policies are an agreement between the insurance carrier and myself. Furthermore, I understand that Suburban Podiatry will prepare any forms to assist me in making collections from the insurance company and any amount will be credited to my account. However, I agree that all services rendered are charged directly to me and I am personally responsible for payment. I also agree to pay any and all expenses, costs for attorney and/or collection fees incurred by Dr. William Czarnecki in attempting to collect amounts due and not promptly paid.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize Dr. William A. Czarnecki and his associates employed by his practice to release any and all medical test results or other medical private health information relating to my treatment to:

Please initial your choices that are acceptable to you. If you do not want an option, please leave it blank to indicate we do not have your permission to use that choice.

_____ May leave message at work or call the office.
_____ May leave message on answering machine/voice mail to call office.
_____ May leave message with family member to call office.
_____ May leave test results on answering machine/voice mail.
_____ May give test results to designated person:
Name:_____

Relationship:_____
_____ May release test results and other private health information only to myself.

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

By signing below, I acknowledge that I have read and agreed to the above Authorization & Release.

Signature_____Date_____

Printed Name_____

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MEDICAL INFORMATION

This Information is Important for Our Records and Your Health

Name_____Date_____

Describe your foot problem_____

_____

Have you tried anything to treat the problem?_____

How long has it been bothering you? Days _____ Weeks _____ Months _____ Years_____

Please indicate which foot problems you now have or have had in the past:

- ❑ Ankle Pain
- ❑ Corns and Calluses
- ❑ Foot or Leg Cramps
- ❑ Plantar Warts
- ❑ Athlete's Foot
- ❑ Numbness in Feet or Legs
- ❑ Heel Pain
- ❑ Swelling in Ankles or Feet
- ❑ Bunions
- ❑ Flat Feet
- ❑ Ingrown Toenails
- ❑ Tired Feet

Height _____ Current Weight _____ Shoe Size _____

ALLERGIES

Are you allergic to or sensitive to:

- ❑ Adhesive/Tape
- ❑ Anesthetics
- ❑ Anticoagulants
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Iodine
- ❑ Latex
- ❑ Novocain
- ❑ Penicillin
- ❑ Sulfa
- ❑ Others_____

MEDICATIONS

What medications do you take regularly?
Please include prescriptions, over-the-counter medications, and vitamins. _____

_____

_____

Name of Pharmacy or Drug Store:

_____

GENERAL HEALTH INFORMATION

Phone # _____

Do you have **diabetes**? ❑Yes ❑No If yes, do you take insulin? ❑Yes ❑No Number of years that you've had diabetes____

Please list any surgeries you have had_____

_____

Hospitalizations other than for the surgeries listed_____

Are you under a physician's care? ❑Yes ❑No If yes, for what condition? _____

Physician_____ Date you last saw this Doctor _____

May we contact your physician about your health? ❑Yes ❑No Physician's Phone Number _____

Do you smoke? ❑Yes ❑No Number of packs per day _____ How many years have you smoked? _____

Did you previously smoke? ❑Yes ❑No Number of years _____

Do you drink alcohol or beer? ❑Yes ❑No If yes, how much? ❑Less than 1-2 per week ❑1-2 per day ❑More than 2 per day

Do you drink caffeinated beverages? ❑Yes ❑No Number of cups/cans per day_____

Employment: Sit at job _____ Stand at job _____ Stand & walk at job _____ Retired _____ Homemaker _____

Athletic activities in which you participate. (please list and indicate frequency)_____

_____

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MEDICAL INFORMATION

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MEDICAL HISTORY

Please check which best describes your general health: ❑Excellent ❑Good ❑Fair ❑Poor

Please check any of the following you have, or have had a problem with in the past:

- ❑ Aids/HIV
- ❑ Asthma
- ❑ Chemical Dependency
- ❑ Diabetes
- ❑ Foot or Leg Cramps
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Phlebitis
- ❑ Tuberculosis
- ❑ Slow or Non-healing wounds
- ❑ Anemia
- ❑ Back Problems
- ❑ Chest Pain
- ❑ Ear Problems
- ❑ Frequent Infection
- ❑ Hemophillia
- ❑ Liver Disease
- ❑ Psychiatric Disorders
- ❑ Stomach Ulcers
- ❑ Swelling of the feet/ankles
- ❑ Angina
- ❑ Bleeding Disorders
- ❑ Chronic Diarrhea
- ❑ Epilepsy
- ❑ Gout
- ❑ Hepatitis
- ❑ Neurological Problems
- ❑ Respiratory Disorders
- ❑ Stroke
- ❑ Other_____
- ❑ Arthritis
- ❑ Cancer
- ❑ Circulatory Problems
- ❑ Fainting/Dizziness
- ❑ Headaches
- ❑ High Blood Pressure
- ❑ Nose Problems
- ❑ Shortness of Breath
- ❑ Varicose Veins
- ❑ Other _____

Women Only: Are you pregnant? ❑Yes ❑No Breastfeeding? ❑Yes ❑No Taking Oral Contraceptives? ❑Yes ❑No

Is there a family (blood relative) history of any of the following medical problems:

- ❑ Heart Disease
- ❑ Arthritis
- ❑ Bleeding Disorder
- ❑ Circulation problems of the legs / feet
- ❑ Neurological Disease
- ❑ Stroke
- ❑ Diabetes
- ❑ Bunions
- ❑ Hammertoes
- ❑ Flatfeet

Additional Comments:_____

_____

_____

_____

_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, administer and after consultation, perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet.

_____

Signature **Date**

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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.

- 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.
- 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 benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If you insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangement 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 require you to pay the co-pay/co-insurance/deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the even your health plan determines 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 even the office is not informed, you will be responsible for any charges denied.
- 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.

By signing below, I acknowledge I have read and agreed to the above Patient Financial Policy.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____Date:_____

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