The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS

Patient Name: _____Date of Birth: ___/___/_____ Age: _____

Reason for your visit today:

Have you ever been to a Podiatrist before?

☐ **YES** ☐ **NO**

If yes, please list:

Name _____Date of Last Visit: _____

Address : _____

City:_____ State:_____ ZipCode:_____

Home #: ( )_____Mobile #: ( )_____ Email address: _____

Primary Language_____ Race_____ Ethnic origin___ _____

Sex:

☐ **Male** ☐ **Female**

Weight: _____ Height _____

Marital Status:

☐ **Single** ☐ **Married**

☐ **Widowed** ☐ **Divorced/Separated**

Occupation: _____

Employer :_____

EMERGENCY CONTACT

Name: _____Relationship: _____Phone: ( )_____

REFERRAL DETAILS

Referred by:_____

Name of Family Physician/Pediatrician: _____

Phone (_____)_____-_____

Date Last Seen by Family Physician :____/____/_____ (MM/DD/YYYY)

Preferred Local Pharmacy/address/phone: _____

_____ _____

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

INSURANCE DETAILS

Primary Insurance Company: _____ **Insurance ID Number:**
Type of Insurance:
Co-pay: $_____
Policy Holder's Name: _____
Relationship to patient:
Subscriber Birth Date: ____/____/_____ (MM/DD/YYYY)

Secondary Insurance Company: _____ **Insurance ID Number:**
Type of Insurance:
Co-pay: $_____
Policy Holder's Name: _____
Relationship to patient:
Subscriber Birth Date: ____/____/_____ (MM/DD/YYYY)

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to The Foot and Ankle Center, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE_____

Relationship_____ Date ____/____/_____ **(MM/DD/YYYY)**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to The Foot and Ankle Center, Inc for any services furnished me by the physicians in that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services.

BENEFICIARY SIGNATURE:_____**Date: ____/____/_____ (MM/DD/YYYY)**

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

FINANCIAL POLICY

Please read each line to ensure you understand our policies:

NO SHOW: 24 hours notice is required for cancellation of your appointment. **Failure to provide 24 hours notice of cancellation will incur a $30 fee**. If you fail to provide cancellation notice on 2 separate occasions, you will have to discontinue care with our providers.

COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required **before** meeting with the doctor. Please call your insurance company if you disagree with this.

DEDUCTIBLES & CO-INSURANCE: If you have not met your deductible, we may collect a **$125** deposit to apply towards your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.

SELF-PAY PATIENTS: Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we cannot see you per your insurance and may need to reschedule your appointment.

SURGERY CANCELLATION: Failure to provide **5 business days** notice of cancellation prior to scheduled surgery date will incur a **$500** fee.

BALANCES/COLLECTION FEES: If balance is not collected within 30 days from the postmark date of a mailed statement, a late fee may be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **$35** administrative fee will be added. We accept cash, checks, all major credit cards and for convenience, payments can be made securely through Square and our Patient Portal.

FMLA/DISABILITY: There is a **$30** charge for completion of these forms.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____ **Date:**____/____/_____ **(MM/DD/YYYY)**

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

PROBLEM LIST/ PAST MEDICAL HISTORY

Part 1: Have you been diagnosed with any of the following (currently or in the past)? Please check/circle:

- ☐ Abdominal Pain
- ☐ Aids/HIV
- ☐ Allergies to Anesthetics
- ☐ Allergies to Meds/Drug
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves/Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Colitis, Ulcerative
- ☐ COPD
- ☐ Crohn's
- ☐ Deep Vein Thrombophlebitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Dizziness
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Foot or Leg Cramps
- ☐ GERD
- ☐ GI Bleed
- ☐ Gout
- ☐ Guillain Barre Syndrome
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Incontinence
- ☐ Irritable Bowel
- ☐ Kidney Problems
- ☐ Kidney Stone(s)
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ MRSA Infection
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pregnant
- ☐ Prostate Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rash
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Swelling in Ankles or Feet
- ☐ Tendinitis
- ☐ Thyroid Disorder
- ☐ Tired Feet
- ☐ Ulcers
- ☐ Urinary Frequency
- ☐ Varicose Veins
- ☐ Vascular Disease, Peripheral

Part 2

List any other important medical condition(s) and or **Surgeries** you have had
Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

Surgical Procedures/Previous Diagnosis	Date(s) or Age

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

MEDICATION LIST

List any medications and vitamins/minerals/herbs that you are currently taking.
Bring Medication Bottles or Completed List with you to appointments.

☐ **No Current Meds**

Medication	Dosage

Pharmacy/Pharmacy Phone Number: ( )

LIST OF ALLERGIES

Please put a check off OR list your Allergies:

- ☐ NO Known Allergies (NKA)
- ☐ NO Known Drug Allergies
- ☐ Adhesive/ Tapes
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local anesthetic, novocaine
- ☐ Penicillin
- ☐ Seafood/shellfish
- ☐ Sulfa
- ☐ Other: _____
  _____
  _____

FAMILY HISTORY

PLEASE LIST ANY PERTINENT FAMILY HEALTH HISTORY: _____

_____ _____ _____

_____ _____ _____

Social History

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

Do you use tobacco products?

☐ Never used ☐ Former use ☐ Current use,___yrs

➔ What type?

☐ Cigarettes ☐ Chewing Tobacco ☐ Cigar

Please describe your current exercise routine:

☐ Inactive ☐ Light ☐ Moderate

Have you ever used any illicit drugs?

☐ Yes ☐ No

➔ **How often**?

☐ Quit ☐ Regular Use

☐ Social Use ☐ Daily Use

➔ **What type**?

☐ Uses marijuana ☐ Uses cocaine ☐ Uses methamphetamine

Do you drink beverages with alcohol?

☐ **Yes** ☐ **No**

➔ How often?

☐ Occasional use ☐ Moderate use ☐ Heavy use

CHIEF COMPLAINT

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

☐ Ankle Pain ☐ Cramps/Numbness ☐ Ingrown Toenails

☐ Athlete's Foot ☐ Flat Feet ☐ Plantar Warts

☐ Bunions ☐ Foot or Leg Cramp ☐ Swelling in Ankles/Feet

☐ Corns & Calluses ☐ Heel Pain Tired feet

Tell us about your current condition, how long, treatments, past imaging (X Rays, MRIs, labs, etc)

_____

_____

CONSENT FOR TREATMENT:

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

Patient/Guardian Signature _____ **Date** ____/____/_____ **(MM/DD/YYYY)**

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

Patient Consent for Medical Photography/ Videography

Patient Name: _____ D.O.B:____/____/_____ **(MM/DD/YYYY)**

Date:____/____/_____ **(MM/DD/YYYY)**

☐ **Check here if minor or unable to provide consent:**

Name of Guardian or legal representative for Minor patient:_____

I consent for medical photographs or videotaping to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, publication, or advertisement. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the Office @ 2156383338. I waive the right of prior approval and hereby release the practitioners of the Foot and ankle center, Inc and any associated staff members from any and all claims for damages of any kind based on the use of my photo information contained.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

_____
Patient Name

_____ ____/____/_____
Signature/ Legal Representative Date: **(MM/DD/YYYY)**

The Foot & Ankle Center, Inc
Your first step towards healthier feet

(215)638-3338
info@facpodiatry.com
2222 Bristol Pike, Bensalem, PA 19020

Acknowledgement of Notice of Privacy Practices (see Notice of Privacy Practices)

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment. By signing this form, you further acknowledge that medical information collected at the Foot and ankle center, Inc will be stored in a medical record system and kept securely in line with state and federal regulations.

_____ _____
Signature or Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

If the patient refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:
_____
_____
_____

May we phone, email, or send a text to you to confirm appointments?
☐ YES ☐ NO

May we leave a message on your answering machine at home or your cell phone?
☐ YES ☐ NO

May we discuss your medical condition with any member of your family?
☐ YES ☐ NO

If YES, please name/phone numbers of the members allowed:
_____
_____
_____