Steven Frank, D.P.M., LLC

FOOT AND ANKLE SPECIALISTS

PATIENT INFORMATION

Date: ____ / ____ / ____
Name (Full) _____ DOB_____
SSN _____ Email Address _____
Address _____ City _____ State _____ Zip_____
Please indicate below the preferred number to contact you
Cell _____ Home _____ Work _____
Marital Status: Single ____ Married _____ Widowed ____ Separated____ Domestic Partner ____ Divorced_____
Sex: Female _____ Male _____
Race/Ethnicity: Asian – African American - Caucasian – Hispanic – Pacific Islander – Native American
Employer _____ Occupation _____
Emergency Contact _____ Relationship to Patient _____
Phone # _____ Alternate _____
Primary Care Physician _____ Phone # _____
Last Seen by Primary _____Referred by _____

RESPONSIBLE PARTY FOR MINORS

Name _____
DL # _____ Issuing State _____
Address _____ City _____ State_____ Zip_____
Primary Contact # _____ Secondary Contact # _____
Employer _____ Occupation _____
Insurance Company _____
Secondary Insurance Company _____

PRIMARY INSURANCE INFORMATION

Policy Holders Name _____ DOB _____
Relationship to Patient _____ Phone # _____
Employer _____ Occupation _____
Insurance Company _____
Address _____ City _____ State_____ Zip_____
Member ID # _____ Group # _____ Phone # _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Policy Holders Name _____ DOB _____
Relationship to Patient _____ Phone # _____
Employer _____ Occupation _____
Insurance Company _____
Address _____ City _____ State_____ Zip_____
Member ID # _____ Group # _____ Phone # _____

Please make sure that we have a CURRENT COPY of your insurance card on file each visit.

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PATIENT HISTORY

Date __ / __ / __ Name _____

PATIENT HISTORY

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

1) What is the main problem with your feet or ankles?

_____

_____

_____

2) When did you first notice the condition?

_____

_____

_____

3) Is this an injury? ___ Yes ___ No

If Yes, when did it occur? __ / __ / ___

If Yes, did it happen at work? ___ Yes ___ No

4) Check all of the following that apply:

Type of Pain __ Burning __ Tingling __ Sharp __ Dull Ache __ Throbbing
__ Shooting __ Stabbing __ Numbness

When Painful __ Upon Standing __ During Walking __ After walking
__ During Sports __ Worse with Activity __ Better as Activity Continues
__ Worse when standing __ With Shoes __ Without Shoes
__ A.M __ P.M __ Lying in Bed __ Always

5) How painful is your condition?

If 0 = "no pain" and 10 = "the worst pain you have ever experienced", please check your pain level:

__ 0 __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10

6) How has this affected your daily routine and what activities does this keep you from performing?

_____

_____

_____

7) Have you had foot care before? __ Yes __ No

By whom and when: _____

_____

_____

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FEET AND ANKLE SPECIALISTS

PATIENT HISTORY

MEDICATIONS

Pharmacy: _____ Number: _____-_____-_____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES

___ NONE ___ OTHER: _____

___ Penicillin ___ Sulfa ___ Iodine ___ Aspirin ___ Anesthetics ___ Latex

___ Codeine ___ Demerol ___ Cortisone ___ Environmental ___ Food

MEDICAL HISTORY

Please check any of the following conditions that you have or have had in the past.

___ Diabetes ___ Heart Disease ___ Poor Circulation ___ Heartburn / Reflux ___ Thyroid Disease

___ Stroke ___ Heart Attack ___ High Blood Pressure ___ Asthma ___ Rheumatic Fever

___ Epilepsy ___High Cholesterol ___ Lung Disease ___ Stomach Ulcers ___ Arthritis

___ Sickle Cell ___ Kidney Disease ___ Tuberculosis ___ Hepatitis ___ Osteoporosis

___ Gout ___ Skin Disorders ___ Glaucoma ___ AIDS (HIV) ___ Bleeding Disorder

Cancer; Type _____

Other: _____

Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes?

_____

_____

When was your last visit? ____ / ____ / _____ What is your average blood sugar reading? _____

Are you pregnant? ___ Yes ___ No How many months? _____

PATIENT HISTORY

SURGICAL HISTORY

Procedure	Date	Complications

1) Have you ever been hospitalized other than for surgery? ____ Yes ____ No Explain _____

_____

_____

2) Have you ever had an injury to the lower extremity? ____ Yes ____ No Explain _____

_____

_____

FAMILY HISRORY

Please check all that apply

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Stroke				
Cancer (what type)				
Other				
Alive or Deceased				

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PATIENT HISTORY

SOCIAL HISTORY

Date of last physical exam: ____ / ____ / ____ Occupation: _____

Activities: _____

Level of Activity: ____ Occasional ____ Weekly ____ Competitive ____ Professional

Do you smoke tobacco? ___ Yes ___ No

If Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____ Yes ____ No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ____ Yes ____ No

If Yes, what type: ____ Beer ____ Wine ____ Hard Liquor

If Yes: How much? ___ < 1 per week ___ 1-2 per week ___ 1-2 per day ___ more than 3 per week

RECREATIONAL DRUG USE

Any type of drug use is a personal choice and will in no way adversely effect you relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ___ Yes ___ No If Yes: What substance and how often used? _____

REVIEW OF SYSTEMS

If you are experiencing any of the following please circle

HEAD: chronic headaches, concussions, dizziness, loss of consciousness.
EYES: glasses, contacts, double vision, blurred vision, blindness, cataracts.
EARS: decreased or loss of hearing, ringing in the ears, chronic earaches.
NOSE: drainage or infection, blockage, bleeding, sinusitis.
THROAT: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech.
CARDIOVASCULAR: chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps
RESPIRATRORY: bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough.
GASTOINTESTINAL: nausea, vomiting, diarrhea, constipation, weight gain loss, blood in stool. Black stool, excessive gas, loss of appetite.
GENITOURINARY: chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina.
GYNECOLOGIC: Irregular or painful periods, absence of period if not in menopause, vaginal discharge.
Other: _____

Do your legs swell? ____ Yes ____ No
Do you have back problems or have had a back injury? _____ Yes _____ No

___ I am not experiencing any of the above symptoms.

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FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive and may create a financial responsibility on your part.

INSURANCE

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.

MEDICARE

We are participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. 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 responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE

Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES

All co-payments and deductibles must be paid at the time of service. We accept the following payment methods: Cash or VISA/MasterCard/Discover/American Express.

ORTHOTICS

Our office can design and create custom orthotics that are tailored to your particular foot disorder or condition. Many insurances cover this service but it is not uniform. Because of the time and cost incurred by our office to provide orthotics, we must charge a nonrefundable 50% deposit at time of order with the remainder due upon receipt of the orthotics.

SELF-PAY

Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES

Please be aware that some of the services you receive may not be covered by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS

We are required to follow the guidelines of your managed care plan, which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care, if required. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

FINANCIAL POLICY

CLAIM SUBMISSION

We will submit your claim to your insurance company; however your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any unpaid balance not covered by your insurance is your responsibly.

PATIENT BILLING

You will be sent three notices regarding your outstanding balance after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third notice, your account will be forwarded to collections. Please notify the billing office if you are unable to pay your bill in full. Payment arrangements may be available. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company sends payment directly to you, it should be forwarded to our office to be applied to your balance. In the event, you do not show up for your appointment, and you failed to call the office to cancel or reschedule, you are defined as a "no-show" and will be billed $25.00.

PRIVACY STATEMENT

Any information disclosed in your records will remain confidential and will not be used for any other reason expect in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

By subscribing my name below, I acknowledge that I was provided a copy of the Notice Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to it's terms.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Steven Frank D.P.M., LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office of there is a change in my health insurance information.

Patient's Name (Print) _____

Signature _____Date _____

Steven Frank, D.P.M., LLC

FOOT AND ANKLE SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of Steven Frank D.P.M., LLC, Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the notice.

Patient Name (Print) _____

Signature_____ Date ___ / ___ / ____

Parent / Guardian' Name (Print) _____

Signature_____ Date ___ / ____ / ___

CONSENT TO TREAT

I certify that the information on the history form is true and correct to the best of my knowledge. I hereby consent and give my permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as maybe deemed necessary in the diagnosis and/or treatment of my feet or ankles.

Patient Name (Print) _____

Signature _____ Date ___ / ___ / ___

Parent / Guardian' Name (Print) _____

Signature_____ Date ___ / ___ / ___

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CONSENT TO RELEASE HEALTH INFORMATION

I understand that in order to disclose my Protected Health Information, Steven Frank D.P.M., LLC must have my consent. Therefore, I authorize Steven Frank, D.P.M., LLC to disclose my Protected Health Information as described on this form, to the recipients listed below: Description of the information to be disclosed (check all that apply):

All Procedures ___ Test Results ___ Appointments ___

Other ___ Surgeries ___ Billing/Account Information ___

Name(s) of the person(s) authorize to obtain the above-mentioned information. Example: physician other than your referring doctor, family members, other specified person(s).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name (Print) _____

Signature _____Date: ___ / ___ / ___