Podiatry Associates, P.C.

Robert Russell DPM - James Bowman DPM

PATIENT INFORMATION FORM
(PLEASE PRINT)

Date: _____

Patient Name:_____ **Date of Birth:** _____ **Age:**_____ **Sex:**
Last First MI

Home Address: _____ **City / State:** _____ **Zip:**_____

May we Leave a Message?

Home Phone #: (____)____-_____ Yes No **Work Phone #:** (____)____-_____ Yes No

Cell Phone #: (____)____-_____ Yes No **Other Phone #:** (____)____-_____ Yes No

Soc-Sec No. _____-_____-_____ **E-Mail:** _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If Yes, Name: _____ Relationship: _____ Phone: (____)____-_____

Emergency Contact: _____ Relationship: _____ Phone: (____)____-_____

Primary Care Doctor: _____ Phone: (____)____-_____

Is there a family member or other person you would like for us to share your medical information?

_____ Yes Name(s) _____ _____ No

Who referred you to our office?_____

Insurance Information

Primary Insurance Company Name:

Insured Name: _____ **Date of Birth:** ___/___/____

Employer: _____

Contract Number: _____ **Group Number:**_____

Secondary Insurance Company Name: -Empty-

Insured Name: _____ **Date of Birth:** ___/___/____

Employer: _____

Contract Number: -Empty- **Group Number:**_____

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Patient name:_____
Date of Birth:_____

Allergies:_____
Pharmacy: _____ **Location:** _____ **Phone:** (____)____-_____
Please list all medications you are currently taking (including prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	Name	Dose

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other then surgery):

Reason for Hospitalization	Date	Reason for Hospitalization	Date

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Use of Tobacco: ☐ Never ☐ Quit - How long ago? _____
☐ Smoke _____ packs / Day for ____ years
Use of recreational drugs: ☐ Never ☐ Quit - How long ago? _____ Type _____
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Employer: _____ Occupation: _____
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily
Types of Exercise: _____

Parent History

Do either of your parents have a history of:
Mother: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid arthritis
Alzheimer's Disease ☐ Other _____
Father: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid arthritis
Alzheimer's Disease ☐ Other _____

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Patient name:_____
Date of Birth:_____

Please choose " Y " for yes if you have ever had any of the following, or choose " N " for no if you have not.

Acid Reflux	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Bladder Infections	Y	N
Abnormal Bleeding	Y	N
Blood Clots	Y	N
Blood Transfusion	Y	N
Bronchitis / Emphysema	Y	N
Cancer	Y	N
Diabetes	Y	N
Other Conditions: _____		

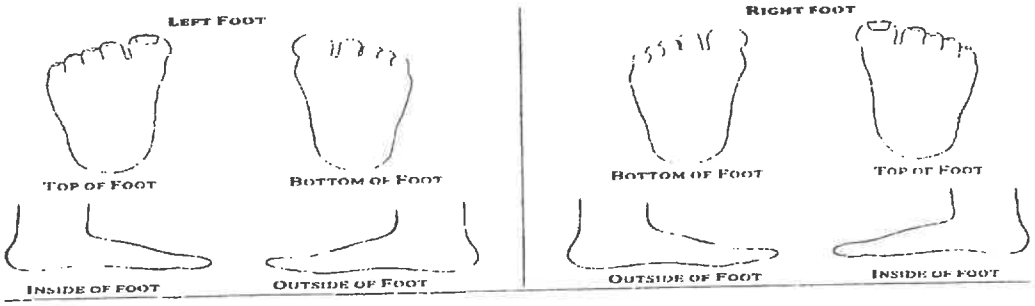
Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart Disease / Failure	Y	N
Hepatitis	Y	N
HIV + /AIDS	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Migraine Headaches	Y	N
Mitral Valve Prolapse	Y	N

Neuropathy	Y	N
Open Sores	Y	N
Pneumonia	Y	N
Polio	Y	N
Rheumatic Fever	Y	N
Sickle Cell Disease	Y	N
Skin Disorder	Y	N
Sleep Apnea	Y	N
Stomach Ulcers	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N

Current Problem

What specific problem brings you to our office today? _____

Where is the pain / problem located? Please mark on the pictures below



Shoe size:_____
How long ago did this problem first start? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time
How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____
How would you rate your pain on a scale from 0 to 10? (Please circle)
{no pain} 0 1 2 3 4 5 6 7 8 9 10 *{worst pain possible}*
Since the time your pain or problem began, hast it: ☐ Stayed the same ☐ Become worse ☐ Improved
What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running
What makes your pain feel better _____
What treatments have you had for this problem? _____**How has this problem affected your lifestyle or ability to work?** _____
Was this problem caused by an injury? _____**If Yes, was it a work-related injury?** ☐ Yes ☐ No

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Patient name:_____
Date of Birth:_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____
Print name of patient, parent or guardian Signature of Doctor

_____ _____
If other than patient, relationship to patient Date

_____
Signature

PATIENT and/or RESPONSIBILE PARTY - FINANCIAL AGREEMENT with Podiatry Associates, P.C.
We will file your insurance for services rendered. It is the responsibility of the patient and/or responsible party to provide the correct insurance information. No oral or written contract except for that of the patient and/or responsible party is acceptable in providing this information. Failure to provide correct information could result in denial of payment by your insurance company. In the event of non-payment by the insurance company you and/or responsible party will be responsible for this account.

I, hereby authorize consent for treatment necessary or desirable for my care/or the patient mentioned on this form. This includes, but is not restricted to, medicine, performance of operation/procedures, and conduct of laboratory or x-rays, dispensing of supplies, that may be use by the attending doctor. The services you receive including supplies that are possible covered by your insurance carrier will be filed to your insurance company, if your insurance does not cover charges filed; the patient, and/or responsible party is responsible for payment of all non-covered services and supplies.

I, hereby acknowledge responsibility for the payment of all services, and agree to pay all amounts due in full at the time of service, (copay, deductible, non-covered items, supplies given to you by doctor or nurses; put in your shoes, etc. or services performed by doctor not covered by insurance), unless other written arrangements are made.

I, hereby authorize my insurance company to remit payment of medical benefits directly to this office for services provided by our physicians. Verification of insurance does not guarantee payment of the claim, if insurance does not pay or respond to the bill: I am responsible to contact the insurance and I agree to pay all charges not paid.

If I, (the patient) change insuracne carriers, (example - if I have Medicare Part B insurance and you sign up for *Healthsprings of Alabama, Viva, Secure Horizons, Advantra Freedom, Wellcare, Humana, Blue Advantage, United Healthcare, AARP, etc.)*, we must be informed of this change with a copy of the insurance card. Some insurance companies require referrals from your primary care provider as well as strict guidelines on the timely filing of claims. When any patient becomes Medicare age an signs up for Medicare Part B, it is the patient's responsibility to show our office their Medicare Card. It is also the patient's responsibility to contact Medicare and inform them of any primary or secondary insurance updates / changes. I understand that it is my responsibility to make sure our office has the correct insurance information and a copy of the correct insurance card. I also understand that I am responsible for providing our office with a picture ID (such as a current drivers license), to keep on file as proof of who I am.

If my insurance requires prior authorization for visits to Podiatry Associates, PC: Dr. Robert I. Russell - Dr. James H. Bowman - it is the patients responsibility to call their primary care physician's office to obtain authorization. Podiatry Associates must receive authorization prior to the appointment date; if we do not receive the authorization by the appointment date, the patient will be require to pay for the visit in full or reschedule the appointment.
In the event the correct insurance information for any of my visits and my insurance had changed and the correct information was not given to Podiatry Associates; it is the patient's responsibility to pay for services denied by insurance carrier. Some insurance companies have a 45 - 180 day filing limit. Medicare has only 12 months to file a claim from the date of service. Podiatry Associates must have the correct information to file charges within the filing period or the patient is responsible for the charges in full.

There are some services and items for maintenance of good health that may not be covered by my insurance carrier, (example: items that go into the patient's shoes or used on t their feet or nails; services not considered medically necessary by some insurance company standards), I understand [I the patient] is responsible to pay for these items.

Not all insurance companies cover: Supplies, Orthotics and Therapeutic (Diabetic) shoes. All coverage of benefits are determined by insurance carrier/group: it is best to check with your insurance company on your coverage and exclusions on foot care or Podiatry services, copay and deductible amounts. *Supplies and special ordered items such as: (Orthotics, Diabetic shoes) cannot be returned and payment is non-refundable.*
I, hereby authorize the release of all medical records on the patient listed above to the referring and/or primary care physician, as well as all records necessary for the processing of insurance claims when or if requested.
I authorize information released to my Employer such as (Work Excuse, FMLA papers, etc). There is a fee for us to fill out papers for you, FMLA, disability, etc. If my account becomes delinquent, I the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees. The fee can be an additional (33.33%), attorney fees and/or court costs, if such be necessary. The debt will be reflected on your credit rating with any or all credit reporting agencies and you no longer will be able to be seen by our doctors until paid in full.
You agree, in order for us to service your account or to collect monies you may owe, Podiatry Associates, PC and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
I/We have read all of the above and understand my responsibility as the patient and/or responsibility party and have agreed to all the disclosures mentioned.

_____ Date_____ Podiatry Associates Employee Initials_____
Signature of Patient, Parent, Guardian or
Responsible Party