Advanced Foot Care, LLP
Diabetic Center of Excellence

Ira Kraus, DPM   Aaron Solomon, DPM *   Clair Bello III, DPM**
*Michael T. Wiles, DPM   Cheryl Haag, DPM**
**Diplomate, American Board of Podiatric Surgery*

Patient Information

Name:____ **Date of Birth**:___________________ **Age:**____

Address:____
Street   Apt.#   City   State   Zip

S.S.#: ________-_________-__________   **Sex: MALE   FEMALE**

Phone: Home (   )___________________ **Work** (   )_________________ **Cell** (   )___________________

Email:______________________________   **Employer:**___________________________

<u>Emergency Contact</u>:
Name:____**Relationship**:______________________
Phone: Home(   )__________________ **Work**(   )________________ **Cell**(   )____________________

<u>Responsible Party/ Primary Insurance Carrier</u> (If Not Self):

Name:___________________________________ **Date of Birth**:_______________ **Relationship**:_________

Address:____
Street   Apt.#   City   State   Zip

S.S.#: ________-_________-__________   **Sex: MALE   FEMALE**

Phone: Home (   )___________________ **Work** (   )_________________ **Cell** (   )___________________

Employer:_______________________________ **Employer Phone**: (   )________________________________

Please answer for HIPAA compliance

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine or voicemail?

YES NO Patient Signature: ______________________________Date:____________

With whom do you allow us to share your health information if you are unavailable?

Name: ____________________________ Relationship:________________________

Name: ____________________________ Relationship:________________________

Name: ____________________________ Relationship:________________________

What is your primary language? ***Cual es su idioma?*** **____**

How were you referred to our office?:____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Advanced Foot Care, LLP of any changes to the above information.

Patient or Guardian Signature:___________________________________ Date:_________________________

ADVANCED FOOT CARE, LLP ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Advanced Foot Care, LLP. This authorization is valid until I notify Advanced Foot Care in writing that it is revoked.

I understand that I am responsible for giving "Advanced Foot Care, LLP" the correct insurance information at the time services are rendered. Advanced Foot Care, LLP agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Advanced Foot Care, LLP is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Advanced Foot Care, LLP expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee, for each statement that we mail. If you have made arrangements with our office we will not charge the re-billing fee for statements sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee $25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a $25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or court costs incurred by this office.

____

Patient or Patients Guardian or Legal Representative Signature Date

____

Name of Patient or Guardian or Legal Representative Relationship to patient

History & Medical Information

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1. Primary Care Physician: ____
   Phone Number: (   ) __________________ Date of last visit:____________________________

2. What is your height: ______ weight:________ What is your occupation? ____________________________

3. Explain your foot/ankle problem:____

4. When did pain/discomfort begin? (date):____
   Describe pain: discomfort: Burning Numbness Sharp other:____________________

5. What makes pain/discomfort better?:____

6. What makes pain/discomfort worse?:____

7. Has condition been treated?: YES NO When and how:________________________________

8. Past Medical History:

Anemia	Gout	Kidney Disease	Other Arthritis
Bleeding Disorders	Heart Disease	Lung Disorders	Prostate Disorders
Cancer	Hepatitis	Mitral Valve Prolapse	Rheumatic Fever
Diabetes	High Cholesterol	Nerve Disorders	Thyroid Disorders
Epilepsy	HIV/ Aids	Neurologic	Stroke
	High Blood Pressure	Osteoarthritis	Other:_________

9. List all Medications/herbs/vitamins: None

____

____

What pharmacy do you use? ____________________________________ Phone #__________________________

10. Allergies: None

Penicilin	Sulfa Drugs	Radiographic Contrast/ Dyes
Narcotic Agent/ Codeine	Aspirin	Shellfish
	Anesthesia	Other ______________________

11. Have you ever had Surgery? (Please list any and all) YES NO
Describe:(surgery/date):____

____

12. Social History:
   Current tobacco Use ________ (How much) Past tobacco use Alcohol use Caffeine Use
   Exercise Habits______________ Drug Use* (recreational,IV) Are you pregnant? Nursing

13. Family history: (list relationship of member(s) who have had problems)

Diabetes	Heart Disease	Bleeding Disorders	Mental Illness
High Blood Pressure	Stroke	Kidney Disease	Cancer
Rheumatology	Other Family History:_______________________________		

Advanced Foot Care, LLP Review of Systems

1. Constitutional Symptoms:

Fevers | Chills | Sweats | Weight Loss | NONE

2. **Head, Eyes, Ears, Nose and Throat:** Do You…

Wear:	Contacts	Dentures	Eyeglasses	NONE
Have:	Double Vision	Cataracts	Dizziness	Ringing in Ears
	Difficulty Swallowing	Neck Pain	Sore Throat	
	Nose Bleeds	NONE		

3. Cardiovascular:

Chest Pain/Heart Attack | Congestive Heart Failure | Heart Murmur | Palpitations
Swelling in Legs/Ankles | Leg Pain w/ Exercise | Cardiovascular **Surgery** | **NONE**

4. Hematological/Lymphatic (blood) History of:

Bleeding abnormalities | Anemia | Lump In Groin or Armpit | Lymphoma
Swollen Glands | NONE

5. Respiratory:

Shortness of Breath | Emphysema | Cough | Bronchitis
Difficulty Breathing | Wheezing | Asthma | Previous Pulmonary Disease
TB (tuberculosis) Exposure or Treatment | Pneumonia | NONE

6. Gastrointestinal:

Nausea | Vomiting | Diarrhea | Constipation | Stomach Ulcers
Decrease in Appetite | Blood in Stool | Hepatitis | Acid Reflux | NONE

7. Endocrine:

Often Thirsty | Often Urinating | Kidney Disease | Pancreatitis
Diabetes Mellitus | Prostate Problems | Thyroid Disorder | NONE

8. Musculoskeletal:

Tendonitis | Bursitis | Broken Bones | Arthralgia
Weakness Of limbs | Feeling Weak | Joint Pain | NONE

9. Nervous System: History Of…

Migraines | Seizures | Strokes | Nervous Disorders
Ataxia (loss of balance) | Aphasia (loss of speech) | Confusion | Fainting
Neuropathy (loss of sensation) | Speech Difficulties | NONE

10. Integumentary:

Rash | Skin Ulcers | Lesions | Sensitivity to Sun
Change in Skin Color | Growth on Skin | Recurrent Infections | Cracking of the Skin
Eczema | Keloid | Hair Loss | NONE

11. Psychiatric: History Of…

Nervousness | Tension | Depression | NONE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: ______________________________________ **Date:** ________________

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. **

____ _________________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____**Signature**

<u>** Packets are available at the front window.</u>