NEW PATIENT INTAKE FORM

Welcome to our practice **CHART #**

PATIENT INFORMATION

LEGAL NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

SEASONAL ADDRESS: _____
STREET CITY STATE ZIP

DATES AT SEASONAL ADDRESS: _____ Thru _____ PREFERRED WAY OF CONTACT: ❑ HOME ❑ WORK ❑ CELL
Month Month

PHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

EMAIL: _____ I AUTHORIZE EMAIL CONTACT ❑ YES ❑ NO

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS #: _____ SEX: ❑ MALE ❑ FEMALE

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ SEPARATED ❑ OTHER PREFERRED LANGUAGE: _____

EMPLOYED: ❑ YES ❑ NO EMPLOYER: _____ Occupation: _____

EMERGENCY CONTACT: _____ PHONE: ( ) _____
NAME / RELATION

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE : _____

RACE: ❑ WHITE ❑ BLACK ❑ HISPANIC ❑ ASIAN ❑ AMERICAN INDIAN ❑ OTHER _____

ETHNICITY: ❑ AFRICAN AMERICAN ❑ AMERICAN ❑ AMERICAN INDIAN ❑ HISPANIC ❑ ITALIAN ❑ OTHER _____

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY. IF THE PATIENT IS A MINOR OR UNDER THE SUPERVISION OF A LEGAL GUARDIAN, THEN THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION. IF THIS DOES NOT APPLY, THEN YOU MAY SKIP TO THE NEXT SECTION.

GUARANTOR INFORMATION

NAME: : _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

DATE OF BIRTH: _____ AGE: _____ LAST 4 DIGITS SS#: 000-00- _____

EMPLOYED: ❑ YES ❑ NO EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR INSURANCE BENEFITS? ❑ YES ❑ NO

PRIMARY INSURANCE NAME: _____ POLICY ID #/GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

INSURED DOB: _____ Relation: _____ LAST 4 DIGITS SS#: 000-00- _____

SECONDARY INSURANCE NAME: _____ POLICY ID #/GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

INSURED DOB: _____ Relations: _____ LAST 4 DIGITS SS#: 000-00- _____

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE. IT WILL ASSIST THE DOCTOR IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION IS CONFIDENTIAL.

MEDICAL HISTORY:

REASON FOR YOUR VISIT : _____

_____

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR **(DATE)**? _____ **PAIN LEVEL:** mild mod severe

PLEASE DESCRIBE YOUR PAIN / DISCOMFORT: ❑ BURNING ❑ NUMBNESS ❑ SHARP ❑ OTHER _____

WHAT MAKES YOU PAIN / DISCOMFORT BETTER? _____

WHAT MAKES YOUR PAIN / DISCOMFORT WORSE? _____

HAS THIS CONDITION BEEN PREVIOUSLY TREATED? ❑ YES ❑ NO HOW AND WHEN? _____

_____

HAVE YOU HAD PRIOR SURGERY ANY WHERE ON YOUR BODY? ❑ YES ❑ NO IF YES, ***PLEASE LIST TYPE AND DATE OF SURGERY***:

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

BP:	PULSE:	Last primary doctor appointment:

HEIGHT	WEIGHT	SHOE SIZE

FLU VACCINE THIS YEAR: □YES (date: _____) NO

PNEUMOCOCCAL VACCINE □YES (date: _____) NO

LAST TETANUS WITHIN 10 YEARS □YES (date: _____) NO

OUR OFFICE GROWS MAINLY BY REFERRAL FROM OTHER PATIENTS. WHOM MAY WE THANK FOR

REFERRING YOU TO OUR OFFICE? _____

ARE YOU BEING TREATED FOR OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING?

ALCOHOLISM	❑ YES ❑ NO	HEART ATTACK	❑ YES ❑ NO
ANEMIA	❑ YES ❑ NO	HEPATITIS OR JAUNDICE	❑ YES ❑ NO
ARTHRITIS	❑ YES ❑ NO	HIGH BLOOD PRESSURE	❑ YES ❑ NO
ASTHMA	❑ YES ❑ NO	HIV / AIDS	❑ YES ❑ NO
BRONCHITIS OR EMPHYSEMA	❑ YES ❑ NO	KIDNEY TROUBLE	❑ YES ❑ NO
CANCER OR TUMOR	❑ YES ❑ NO	MITRAL VALVE PROLAPSE	❑ YES ❑ NO
CHOLESTEROL / TRIGLYCERIDES	❑ YES ❑ NO	RHEUMATIC FEVER	❑ YES ❑ NO
DIABETES (Type I, II, Gestational)	❑ YES ❑ NO	STOMACH ULCERS	❑ YES ❑ NO
Last Blood Sugar # / A1C_____How Long? ___ _____		STROKE	❑ YES ❑ NO
DRUG ABUSE	❑ YES ❑ NO	THROMBOPHLEBITIS or DVT	❑ YES ❑ NO
EPLIEPSY OR SEIZURE	❑ YES ❑ NO	THYROID DISEASE	❑ YES ❑ NO
GOUT	❑ YES ❑ NO	TUBERCULOSIS	❑ YES ❑ NO
DO YOU REQUIRE PREMEDICATION BEFORE DENTAL PROCEDURES (ANTIBIOTICS)			❑ YES ❑ NO

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED TO ANY OF THE FOLLOWING?

PENICILLIN	❑ YES ❑ NO	GENERAL ANESTHESIA	❑ YES ❑ NO
ASPIRIN	❑ YES ❑ NO	LIDOCAINE/NOVACAINE (LOCAL ANESTHESIA)	❑ YES ❑ NO
BAND AIDS / TAPE	❑ YES ❑ NO	RADIOGRAPHIC CONTRAST / DYE	❑ YES ❑ NO
CODEINE	❑ YES ❑ NO	SEDATIVE	❑ YES ❑ NO
IODINE	❑ YES ❑ NO	SULFA DRUGS	❑ YES ❑ NO
		LATEX	❑ YES ❑ NO

Other not listed? _____

SOCIAL HISTORY:

DO YOU USE TOBACCO?	❑ YES ❑ NO	DO YOU USE RECREATIONAL DRUGS?	❑ YES ❑ NO
IF YES, HOW MANY PACKS PER DAY AND FOR HOW LONG?	_____/_____	DO YOU EXERCISE ON A REGULAR BASIS?	❑ YES ❑ NO
ARE YOU PREGNANT? *IF YES, DELIVERY DATE?*	❑ YES ❑ NO _____	ARE YOU NURSING?	❑ YES ❑ NO
DO YOU DRINK ALCOHOL?	❑ YES ❑ NO	DO YOU DRINK CAFFEINE?	❑ YES ❑ NO

Family History

PLEASE LIST YOUR RELATIONSHIP TO THE FAMILY MEMBER WHO HAS HAD THE FOLLOWING PROBLEMS:

BLEEDING DISORDERS	❑ YES ❑ NO	_____	KIDNEY DISEASE	❑ YES ❑ NO	_____
CANCER	❑ YES ❑ NO	_____	MENTAL ILLNESS	❑ YES ❑ NO	_____
DIABETES	❑ YES ❑ NO	_____	RHEUMATOLOGY	❑ YES ❑ NO	_____
HEART DISEASE	❑ YES ❑ NO	_____	STROKE	❑ YES ❑ NO	_____
HIGH BLOOD DISEASE	❑ YES ❑ NO	_____	OTHER		_____

REVIEW OF SYSTEMS

CARDIOVASCULAR: ❑ **NONE**
- ❑ CALF PAIN WITH EXERCISE / WHILE SLEEPING
- ❑ CHEST PAIN/HEART ATTACK
- ❑ CONGESTIVE HEART FAILURE
- ❑ HEART FAILURE
- ❑ PALPITATIONS

CONSTITUTIONAL SYMPTONS: ❑ **NONE**
- ❑ FEVER
- ❑ CHILLS
- ❑ SWEATS
- ❑ WEIGHT LOSS

ENDOCRINE: ❑ **NONE**
- ❑ EXCESS SWEATING
- ❑ FREQUENT/DIFFICULTY URINATING
- ❑ OFTEN FEELING HOT/COLD
- ❑ OFTEN HUNGRY
- ❑ OFTEN THIRSTY
- ❑ PANCRETITIS
- ❑ PROSTATE PROBLEMS

GASTROINTESTINAL: ❑ **NONE**
- ❑ ACID REFLUX
- ❑ BLOOD IN STOOL
- ❑ CONSTIPATION
- ❑ DECREASE IN APPETITE
- ❑ DIARRHEA
- ❑ NAUSEA
- ❑ VOMITING

HEAD, EYES, EARS, NOSE, AND THROAT: ❑ **NONE**
- ❑ CATARACTS
- ❑ CONTACTS
- ❑ DENTURES
- ❑ DIFFICULTY SWALLOWING
- ❑ DIZZYNESS
- ❑ DOUBLE VISION
- ❑ EYEGLASSES
- ❑ NECK PAIN
- ❑ NOSE BLEED
- ❑ RINGING IN EARS
- ❑ SORE THROAT

HEMATOLOGICAL/LYMPHATIC: ❑ **NONE**
- ❑ BLEEDING ABNORMALITIES
- ❑ LUMP IN GROIN/ARMPIT
- ❑ SWOLLEN GLANDS

INTEGUMENTARY (SKIN): ❑ **NONE**
- ❑ BIRTHMARKS
- ❑CHANGES IN SKIN COLOR
- ❑ ECZEMA
- ❑ GROWTH ON SKIN
- ❑ HAIR LOSS
- ❑ LESIONS
- ❑ PIERCING
- ❑ RASH
- ❑ RECURRENT INFECTIONS
- ❑ SENSITIVITY TO SUNLIGHT
- ❑ TATTOOS
- ❑ SKIN ULCERS / WOUNDS IN THE PAST

MUSCULOSKELETAL: ❑ **NONE**
- ❑ BURSITIS
- ❑ JOINT PAIN/SWELLING/STIFFNESS
- ❑ PRIOR FRACTURE/SPRAINS
- ❑ TENDONITIS
- ❑ WEAKNESS OF LIMBS

NEUROLOGICAL: ❑ **NONE**
- ❑ CONFUSION
- ❑ FAINTING
- ❑ INSOMNIA
- ❑ MIGRAINES
- ❑ NERVOUS DISORDERS
- ❑ NEUROPATHY (LOSS OF SENSATION)
- ❑POOR BALANCE
- ❑ SPEECH DIFFICULTIES

PSYCHIATRIC: ❑ **NONE**
- ❑ DEPRESSION
- ❑ NERVOUSNESS
- ❑ TENSION

RESPIRATORY: ❑ **NONE**
- ❑ COUGH
- ❑ DIFFICULTY BREATHING
- ❑ SHORTNESS OF BREATH
- ❑ WHEEZING

To the best of my knowledge, the questions above were accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Patient name and signature of patient / parent / POA:		
	(Signature)	(Date)
Physician's signature:		
	(Signature)	*(Date)*

OFFICE POLICY

Welcome to Our Office

Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining the health of your feet. Our practice will strive to provide you with the finest quality podiatric care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments

If you are unable to keep an appointment please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule. **You may be charged the cost of the scheduled visit (Minimum $45).** If you have a scheduled surgical appointment and is not cancelled 1 week prior to scheduled date, you will be charged a $250 surgical set up fee. These fees are not covered by your insurance.

Leaving Messages

Our office policy is to leave generic, harmless information on answering machines. We would like to accommodate our patients and can do so by initialing next to your preference.

1. _____leave very little information.

2. _____please call #_____and leave specific details.

3. _____please leave as much information as possible on the machine or with anyone who answers my phone.

Transferring Records

If you want to have copies of your records, you must authorize us to include all relevant information, including your payment history **upon request**. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history. **There will be a $10 copying fee per film for x-rays.**

Financial Policy

This is an agreement between Albany Family Foot and Ankle Services PC, as creditor and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the Albany Family Foot and Ankle Services, P.C.. By executing this agreement you are agreeing to pay for all services rendered.

Insurance

Insurance is a contract between you and your insurance company. (We are **not** a party to this contract, in most cases). We will bill your primary insurance company only if we are a contracted participating provider. We will accept secondary insurances for Medicare only, as long as it is medigapped (automatic crossover). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what podiatric coverage is available on your policy. This can only be done on the day of your appointment if time permits. **You as the policyholder are primarily responsible to verify benefits**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Referrals

If your insurance company requires a referral and/or preauthorization/pre-certification **you are responsible for obtaining it**. We most likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Workers Compensation

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Required Payments

Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payment Options

You may choose to pay cash, check, or credit card on the day that the treatment is rendered.

Returned Checks There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Payments
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Finance Charge
A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at an annual percentage rate of one percent (1%) per month or an annual percentage rate of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of our account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and the subtracting any payments or credits applied to the account during that time. The minimum finance charge is $50.00.

FMLA and Disability Forms
There will be a $20.00 charge for completing FMLA and disability paper work. Please submit paper work one week prior to due date.

Past Due Accounts
If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Albany County, NY

Waiver of Confidentiality
You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date
Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

PATIENT'S SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **NOTICE OF PRIVACY PRACTICES** by the **Albany Family Foot and Ankle Serivces, PC** and that I have read (or had the opportunity to read if I so chose) and understood the notice.

PATIENT'S SIGNATURE _____ DATE _____

I GIVE AUTHORIZATION TO DISCUSS MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

NAME	RELATIONSHIP	DATE OF BIRTH

MEDICAL INFORMATION RELEASE

I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

PATIENT'S SIGNATURE _____ DATE _____

PHARMACY INFORMATION:

PHARMACY NAME **:** _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

DO YOU TAKE MEDICATION ON A DAILY BASIS, INCLUDING PILLS, INJECTABLES, OR HERBS? ❑YES ❑ NO ❑ SEE ATTACHED LIST

Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:
Medication name:	Dosage:

I authorize Albany Family Foot and Ankle Services, PC to download my medication history and Rx benefits into my account from an Rx clearinghouse.

_____ _____
PATIENT'S SIGNATURE DATE:

PLEASE USE THIS PAGE FOR ANY ADDITIONAL INFORMATION AND COMMENTS: