Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name**: _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other (*specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers ☐ constipation
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis ☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown
☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever
☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Review of Symptoms (Please check each symptom that applies to you.)

Allergic/Immunologic:

___Recent asthma attack ___Environmental allergies ___Weak immune system
___Eyes watering ___Hay Fever ___Sensitivity to dust

Constitutional/General:

___Chills ___Dizziness ___Fatigue ___Tiredness ___Malaise
___Night Sweats ___Weight Gain ___Weight loss (unintentional) ___Weight loss (intentional)

Eyes, Ears, Nose, Mouth & Throat:

___Bloody Nasal discharge ___Dental Problems ___Ear Problems ___Headaches
___Sinus congestion ___Sore Throat ___Abrupt Visual loss ___Eye/vision problems
___Motion sickness ___Ringing in ears ___Glasses ___Neck Pain
___Swelling/nodes

Endocrine:

___Bone loss ___Cold Intolerance ___Cuts take longer to heal ___Dry Hair
___Dry Skin ___Extreme thirst ___Heat Intolerance ___Polypuria
___Weight Change ___Hyperglycemia (high glucose levels) ___Hypoglycemia (low glucose levels)

Psychiatric:

___Agitation ___Anxious feelings ___Depression ___Libido decrease ___Panic Attacks
___Suicidal thoughts ___Psychiatric or emotional difficulties ___Irritability

Shoe Size: _____ N /M / W / XW

Due to the HIPAA rules and regulations the following is prohibited in the exam rooms:

- Cell phone use of any kind to include but not limited to: photography, video, recording, voice recording
- No food and/or drinks

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):
   Name: _____Phone #: _____
   Name: _____Phone #: _____
   Name: _____Phone #: _____
2. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than home. (Confidential Communications)
   _____
3. I understand the Privacy Protection Act and have been offered a copy of the Practice's Notice of Privacy Practices.
   To the best of my knowledge, the information provided on these forms has been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the doctor's office of any changes in my (or my child's) health. I also authorize the healthcare staff to perform necessary health care services I (or my child) may need. I have been informed that if I am uncertain about any questions on this form, I should ask the doctor or a member of staff for assistance.

Patient/Representative Signature_____Date:_____

Printed: _____Reviewed by:_____

Patient Financial Policy and Assignment of Benefits

- As our patient, YOU are responsible for all authorizations/referrals needed to seek treatment in this office.
- I understand that I am responsible for giving Chapel Podiatry & Associates, PA the correct insurance information at the time services are rendered. In the event that the office is not informed you will be responsible for any changes denied.
- Your insurance policy is a contract between YOU and YOUR insurance company. As a courtesy, we will file your insurance claim including any supplement insurance claims. You, the patient and/or guardian, accept reassignment of benefits for your services to be paid directly from your insurance company to: Chapel Podiatry & Associates, PA. If your insurance company does not remit payment within 60 days you will be billed for the remaining balance.
- You will be responsible for any copayments, deductibles and/or co-insurance not covered by your insurance at the time services are rendered.
- Our office DOES NOT accept checks for in office payments! We accept all major credit cards, cash, debit and care credit for payment.
- Your insurance company may not cover all services needed for your care; these are determined as "non-covered" services. You will be responsible for any "non-covered" services at the time service is rendered.
- Past due accounts are subject to collection proceedings. All costs incurred, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to our office.
- I understand that there is a $25 charge applied to my account for a missed appointment if not notified within 24 hours of scheduled appointment. This is NOT covered by your insurance.
- I understand that there is a $25 fee for returned checks should you mail in a payment.
- If you should be sent to collections, you will be considered discharged from our practice and it will be your responsibility to locate another physician.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND & AGREE TO ABIDE TO THE CONDITIONS SET FORTH IN THIS FINANCIAL POLICY.

_____

PATIENT (GUARDIAN) SIGNATURE / DATE PATIENT NAME (PRINTED)

_____

EMPLOYEE / WITNESS SIGNATURE / DATE