

Today's Date _____

Mr./Mrs./Miss/Ms./Dr. _____
(circle one) First Name Middle Initial Last Name

Address: _____

City State Zip Code

Phone: Home # _____ Work # _____ Cell# _____

Gender: M/F Date of Birth: ____/____/____ Age: _____ SS# _____

CHIEF CONCERN

Please describe your primary foot concern/pain: _____

How did it start? _____ Is this work related? _____

How long has it been bothering you? _____

Any prior foot problems? _____

Shoe Size: _____ Height: _____ Weight: _____ Occupation: _____

Do you... _____ sit at your job? _____ stand at your job? _____ sit & stand at your job?

Are you required to wear a particular type of shoe? If yes, what type? _____

COMPREHENSIVE MEDICAL HISTORY

DO YOU HAVE OR EVER HAVE BEEN TREATED FOR THE FOLLOWING (check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Gout | <input type="checkbox"/> Ear Disorder | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Depression | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Chronic wounds |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Spinal/Disc Problems | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> None of these |

Family/Primary Physician: _____
Name Location Telephone

Preferred Pharmacy: _____
Name City Telephone

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	Yes	No	Type of Reaction You Experienced:
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morphine / Demerol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin / Aleve / Bayer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Advil / Motrin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Novacaine / Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iodine / Shellfish	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other allergies:	_____		

PLEASE LIST YOUR MEDICATIONS (prescription, over-the-counter, topical, herbal): _____

DO YOU HAVE ANY ARTIFICIAL JOINTS? ____ No ____ Yes Where? _____

PLEASE LIST ANY PROCEDURES OR SURGERIES YOU HAVE HAD: _____

DO ANY OF YOUR FAMILY MEMBERS (parents, grandparents, brother, sister) HAVE/HAD ANY OF THE FOLLOWING?

- | | |
|---|---|
| <input type="checkbox"/> Diabetes, who? _____ | <input type="checkbox"/> Bleeding Disorder _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bunions _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hammertoes _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Circulation Problems _____ |

DO YOU SMOKE? ____ No ____ Yes # Packs per Day = _____

HAVE YOU SMOKED IN THE PAST? ____ No ____ Yes When did you quit? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? ____ No ____ Yes # drinks per week: _____

X _____
Signature of Person filling out form Relationship to Patient

INSURANCE INFORMATION

(Please present insurance cards and forms to the receptionist once completed)

First Name Middle Last Date of Birth Chart # (office use)

Primary Insurance Information:

Name of Primary Insurance: _____

Claims Address: _____

Full Name of Primary Insured: _____ DOB: _____

Relationship of Primary Insured to Patient: _____

Primary Insured Employer Name/Address: _____

Phone Number of Employer: _____

Secondary Insurance Information:

Name of Secondary Insurance: _____

Claims Address: _____

Full Name of Primary Insured: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Name of Patient's Power of Attorney (if applicable): _____

Address: _____

Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I acknowledge that I was provided a copy (if requested) of the Notice of Privacy Practices for Quarryville Family Foot Care, P.C., and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name (please print)

Date

Patient Signature

Name of Parent or Authorized Representative (if applicable)

The Responsible Parties whose signatures appear below agree as follows:

- The Doctor and Staff of Quarryville Family Foot Care, P.C., hereafter referred to as QFFC, are authorized to medically treat the patient named on this form and to exchange past, present and future medical information with the patient's other medical caregivers for the purpose of enhancing and promoting the continuity of care for the patient.
- The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize QFFC, or agents thereof, to make credit investigations including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until QFFC receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of maturity.
- Not all services and/or fees are covered by the benefits plan of the Responsible Parties' health care insurance, (i.e., insurance company, HMO, employer or government benefits provider) hereafter referred to as the PLAN. **Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.**
- If any account balance is not paid in full within 60 days, the entire account balance will be subject to a monthly finance charge and a monthly cost of re-billing/account maintenance charge at the following rates: The monthly finance charge is 1.5% (18% Annual percentage rate). The monthly cost of re-billing is \$8.00. These rates are subject to change upon 30 days written notice.
- If any account balance should remain unpaid for 60 days and QFFC refers the account to a collection agency or attorney for collection, the Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.
- Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance overage, the pending of claims thereon or the outcome of medical treatment. All proceeds from the PLAN are assigned to QFFC where applicable. As they are responsible for all charges the Responsible Parties will assist QFFC in every way to collect payments from the PLAN to the extent their help is required.
- The Responsible Parties acknowledge receipt of Quarryville Family Foot Care's Financial Agreement & Authorization for Treatment.

Agreed to and accepted by the Responsible Parties:

X _____ **Date:** _____

(Responsible Party, or Parent/Guarantor)

ASSIGNMENT OF BENEFITS

I hereby name Quarryville Family Foot Care, P.C., as my/our assignee. I instruct my health care benefits plan administrator (i.e.: The Plan) to pay QFFC directly for all professional and medical services provided by QFFC, through the means of electronic fund transfer(s) or by check(s) made payable to and mailed to QFFC.

MEDICARE/MEDIGAP RECIPIENTS: "I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Quarryville Family Foot Care, P.C., for any services furnished by that physician or supplier. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services."

X _____ **Date:** _____