

New Patient Welcome Forms

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Apt. # City State Zip

SSN: ____ - ____ - _____ Sex: M F Email: _____

Phone: Home () _____ Work () _____ Cell () _____

Marital Status: _____

How were you referred to our office? --

PHYSICIAN (name?) _____ GOOGLE _____ MY INSURANCE _____

OTHER _____

Preferred Pharmacy Name and Location: _____

Pharmacy Phone Number: () _____

Primary Care Physician (Family Dr): _____ Date of Last Visit: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: Home () _____ Work () _____ Cell () _____

Insurance Responsible Party

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____
Street Apt. # City State Zip

SSN: ____ - ____ - _____ Sex: MALE or FEMALE

Phone: Home () _____ Work () _____ Cell () _____

Employer: _____ Employer Phone: () _____

Patient Name: _____ DOB: _____

Demographic Update

1. Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

Please circle one: YES or NO

2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check all that apply.

American Indian or Alaskan Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White or Caucasian

I wish to decline answering questions 1 and 2 regarding race and ethnicity

3. What is your primary language?

English Other, please specify: _____

4. (Regardless of your answer to question 3) Do you need an interpreter?

Please Circle One: YES or NO

Patient Name: _____ DOB: _____

Reason for Visiting:

Today's Date: _____

*Please answer the following questions to help our staff provide you with the best quality treatment.

Describe your foot/ankle problem. (Example: right ankle pain)

When did the problem start? (Please give a date or rough estimate. Example: one week ago)

Shortly describe how the pain started. (Example: twisted ankle while hiking)

How painful is your condition? (Scale: 0 = no pain 10 = extremely painful)

Please circle one: 1 2 3 4 5 6 7 8 9 10

Please check all that apply:

Type of pain: Burning Tingling Sharp Dull Ache
 Shooting Stabbing Numbness Throbbing

When does the pain occur?

Standing During walking After walking
 During sports Worse with activity Better as activity continues
 With shoes Without shoes A.M. P.M.
 Lying in bed Always

What makes the pain/condition better (Example: rest, icing, medications, etc.)?

Have you received treatment for this problem? YES or NO

If yes, please describe the treatment: _____

Columbus Podiatry & Surgery Inc.

Patient's Name: _____ DOB: _____

Medical History

Patient Height: ___ ft ___ in Patient Weight: _____ lbs
 Blood Pressure: _____ / _____ Shoe Size: _____

Medication	Dosage	Medication	Dosage

Have you had an allergic reaction to any of these immunizations or medications?

- | | | | |
|--------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> none | <input type="checkbox"/> latex | <input type="checkbox"/> pneumococcal | <input type="checkbox"/> DTaP |
| <input type="checkbox"/> penicillin | <input type="checkbox"/> codeine | <input type="checkbox"/> neomycin | <input type="checkbox"/> Baker's yeast |
| <input type="checkbox"/> sulfa | <input type="checkbox"/> adhesives | <input type="checkbox"/> IPV | other _____ |
| <input type="checkbox"/> iodine | <input type="checkbox"/> cortisone | <input type="checkbox"/> influenza | _____ |
| <input type="checkbox"/> shell fish | <input type="checkbox"/> streptomycin | <input type="checkbox"/> Hep B | _____ |
| <input type="checkbox"/> aspirin | <input type="checkbox"/> rotavirus | <input type="checkbox"/> Hep A | _____ |
| <input type="checkbox"/> anesthetics | <input type="checkbox"/> polymyxin | <input type="checkbox"/> HiB | _____ |

Surgical History

Procedure	Year	Any Complications?

Are you on dialysis? Yes or No

Have you had a kidney transplant? Yes or No

Family History

*Please check all that apply, or write in	Father	Mother	Brother	Sister
Arthritis				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke/Heart Attack				
Kidney or Liver Disease				
Rheumatic Conditions				
Bleeding Disorders				
Cancer (List Type)				
Other:				

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Patient's Name: _____ DOB: _____

Health History

*** Please check any of the following current or past conditions you may have, and list any major concerns**

Diabetes: Please circle your type: Type 1 or Type 2 What was your last A1c reading? _____

Who is managing your diabetes?

Doctor's Name: _____ Phone: () _____

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Conditions |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Skin Disorder | |
| <input type="checkbox"/> Venous Stasis | <input type="checkbox"/> Aids (HIV) | <input type="checkbox"/> Lung Disorder | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Colitis/Chron's | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Gout | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Acid Relux/GERD |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Eczema | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Deaf/Hearing Loss | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Congestive Heart Failure | |
| <input type="checkbox"/> Leg Pains | <input type="checkbox"/> Rheumatic Conditions | <input type="checkbox"/> Swelling of feet/ankles | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Ataxia (Loss of Balance) | <input type="checkbox"/> Multiple Sclerosis (MS) | |
| <input type="checkbox"/> Peripheral Arterial Disease | | <input type="checkbox"/> Peripheral Vascular Disease | |
| <input type="checkbox"/> Psychiatric Disorder: _____ | | <input type="checkbox"/> Cancer: _____ | |
- History of bleeding _____ Are you taking any blood thinners? _____
- Other Major Health Concerns: _____

Social History

- Do you smoke tobacco? Yes No
If Yes: #packs per day? _____ #cigarettes per day? _____ #of years? _____
If No: Did you ever smoke? Yes No
- Do you drink caffeine (teas, coffee, soda/pop)? Yes No
If yes, how many per day? 1-2 3-5 6-9 10 or more
- Do you consume alcohol? Yes No
If yes, how much?: Socially/Rarely Occassionally Daily Recovering
- Are you employed? Yes No Employer: _____

***Any type of drug use is a personal choice and WILL IN NO WAY adversely affect your relationship with the doctor.** However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Do you use recreational drugs? Yes No

If yes, what substance(s) and how often? _____

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

Patient/Guardian Signature: _____

Additional History:

FOR PATIENTS OF ALL AGES:

Have you received a flu vaccination for the current season?

Y

N

If NO, the reason is---Allergy Declined Vaccine-unavailable

FOR PATIENTS 65 OR OLDER:

Do you have a living will or someone to make decisions on your behalf?

Y

N

Have you had a pneumonia vaccination? Y N

AUTHORIZATION FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I consent to and authorize all treatments and care as deemed reasonable and necessary by Columbus Podiatry & Surgery Inc. and agree to be responsible for decisions relating to such.

I also acknowledge that I was provided the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood the Notice and agree to its terms.**

Print Patient Name: _____ DOB: _____

Patient Signature: _____

Date: _____

Parent or Authorized Representative (if applicable): _____

** HIPAA Privacy notification packets are available at the front desk.

HIPAA Compliance

Please answer for HIPAA compliance: May we leave appointment reminders and procedure dates on your home answering machine, cell phone, or other voice communication device voicemail?

Please Circle One: YES or NO

Patient Signature: _____ **DOB:** _____

Date: _____

If the patient is unavailable, do you authorize us to share health information with anyone else?

Please Circle One: YES or NO

Please list authorized personnel:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Preferred Method of communication: Email Fax Cell Mail Text Work Home

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Columbus Podiatry & Surgery Inc. of any changes to the above information.

Patient or Guardian Signature: _____ **Date:** _____

Financial Policy and Responsibility

Thank you for choosing Columbus Podiatry & Surgery Inc. to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive may imply a financial responsibility on your part.

Insurance: We participate in most insurance plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your medical health coverage. If you are not insured by a plan we participate with, full payment for services is expected at each visit. If you are insured by a plan we participate with but do not have a current insurance card, payment in full for each visit is required until your coverage is verified.

Medicare: We are a participating Medicare provider. Medicare, as well as any applicable secondary insurance, will be billed for you. There is no guarantee of service coverage. Patients are responsible for paying their annual deductible if it has not been met. Patients are also responsible for any co-payments. Copayment is typically 20% of the allowed item or service price.

Secondary Insurance: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

Copayments and Deductibles: All co-payments and deductible payments must be paid at the time of service. Your insurance company contracts this arrangement. Failure to collect such payments can be considered fraud. Please help us uphold the law by paying your co-payment at each service visit.

Self-Pay: If you do not have health insurance, full payment for services is due at the time of service.

Non-covered Services: Please be aware that some of the services available at our practice may not be covered by your insurance. Your insurance has the power to deem some medical services unnecessary for your health. If you chose to receive these services, you are responsible for payment.

Referrals/Authorizations: We are required to follow the guidelines of your managed health care plan that may mandate us to require referrals from your primary care physician to see a specialist. If your insurance requires a referral from your primary care physician, it is your responsibility to get a referral from your primary care physician.

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your insurance company's request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays the claim or not. Your insurance coverage is a contract between you and your insurance company.

Patient Billing: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and final notice, your account will be forwarded to collections. Please contact our billing office if you have any difficulties receiving or paying your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: cash, check, or VISA/MasterCard/Discover credit card. An additional \$35.00 will be added to your statement if your check is returned for insufficient funds. In the event that your insurance company send payment to you (the patient), we require payment be forwarded to our office to be applied to the account balance.

Privacy Statement: Any information disclosed in your records will remain confidential and will not be used for any other reason outside of providing you quality care and treatment. Your information might also be used to submit claims to your insurance company and contact you as needed.

Assignment of Benefits: I certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Columbus Podiatry & Surgery Inc. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MY MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Missed Appointments: Our policy is to charge \$35.00 for missed appointments. Missed appointments are considered those not cancelled at least 24 hours in advance to the scheduled appointment. These charged will be your responsibility and billed directly to you. Please help us serve you better by knowing your scheduled appointment date and time.

I understand that it is my responsibility to inform Columbus Podiatry & Surgery Inc. of any changes in my health insurance information. I have read the above policy regarding my *financial responsibility* to Columbus Podiatry & Surgery Inc. for medical services provided. I agree to pay Columbus Podiatry & Surgery Inc. any balance unpaid by my insurance carrier for the signed patient.

Print Patient Name: _____ **Signature:** _____

Print Patient Guardian: _____ **Signature:** _____

Columbus Podiatry & Surgery Inc.

Patient Name: _____ Date: _____

1. Do you experience aching, cramping or pain in you arms, legs, thighs or buttocks when you walk or exercise?

Yes No

2. If you answered “yes” to question 1, does the pain go away with rest?

Yes No

3. Do you have numbness and tingling in your arms, Legs, or feet?

Yes No

4. Are your fingers or toes pale, discolored or bluish? Yes No

5. Are your hands or feet cold to the touch? Yes No

6. Do you have open sores or ulcers on your legs or feet that won't heal?

Yes No

7. Do you exercise on a regular basis? Yes No

If no, what keeps you from exercising? _____

8. Do you have a family history of diabetes or cardiovascular problems (Immediate family: parent, sibling)

Yes No

9. Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms or kidneys?

Yes No

Answers to these questions will determine if a vascular screening will help us better assess your vascular health status.

Patient Signature: _____

Reviewed by (physician): _____

Columbus Podiatry & Surgery Inc.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the entities listed below to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I authorize _____ to disclose my information to _____.

- Complete Medical Record with no limitations placed on dates, history of mental illness, or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse, infectious disorder including HIV/AIDS test results and/or status.
- Confined to records of information regarding the diagnosis and treatment of the following medical conditions : _____.
- Covering records dating from _____ to _____.

Specific Reports to be Disclosed

- | | |
|--|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Emergency Department Reports<input type="checkbox"/> Laboratory Reports<input type="checkbox"/> Discharge Summary<input type="checkbox"/> Physical/Occupational Therapy Notes<input type="checkbox"/> Other : _____ | <ul style="list-style-type: none"><input type="checkbox"/> Operative Reports<input type="checkbox"/> Pathology Reports<input type="checkbox"/> Radiology Reports<input type="checkbox"/> Progress Notes<input type="checkbox"/> Treatment Plan |
|--|--|

I understand that my health care will not be affected if I do not sign this form.
I understand that I may see and copy the information described on this form if I ask for it, in accordance with the office charges for copies. I understand that this authorization will expire one year from the date signed. I understand that I may revoke this authorization at any time in writing, but if I do it won't have any effect on any actions taken before receipt of revocation.

Columbus Podiatry & Surgery, Inc. will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of patient or patient's representative _____ **Date** : _____

Printed name of patient : _____ **patient's D.O.B.** : _____

Printed name of patient's representative (if applicable) : _____

Relationship to the patient (if applicable) : _____