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: _____

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?

__ none
__ penicillin
__ sulfa
__ iodine
__ shell fish
__ aspirin
__ anesthetics
__ latex
__ codeine
__ adhesives
__ cortisone
__ streptomycin
__ rotavirus
__ polymyxin
_pneumococcal
__ neomycin
__ IPV
__ influenza
__ Hep B
__ Hep A
__ HiB
__ DTaP
__ Baker's yeast
other_____
_____
_____
_____

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:				

Columbus Podiatry & Surgery Inc.

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 cirlce your type: Type 1 or Type 2 What was your last A1c reading?_____
Who is managing your diabetes?
Doctor's Name:_____ Phone: ( )_____

__Anemia	__Deep Vein Thrombosis	__Epilepsy	__Nerve Conditions
__Heart Disease	__Arthritis	__Tuberculosis (TB)	__High Blood Pressure
__Osteoarthritis	__Stomach Ulcers	__Skin Disorder	
__Venous Stasis	__Aids (HIV)	__Lung Disorder	__Kidney Disorder
__Stroke	__Hepatitis	__Osteoporosis	
__Colitis/Chron's	__Poor Circulation	__Gout	__Asthma/COPD
__Joint Pain	__Thyroid Disorder	__Rheumatic Fever	__Acid Relux/GERD
__High Cholesterol	__Coronary Artery Disease	__Mitral Valve Prolapse	
__Recurrent Infections	__Eczema	__Muscle Weakness	__Broken Bones
__Speech Difficulties	__Deaf/Hearing Loss	__Neuropathy	
__Prostate Disorder	__Chest Pains	__Congestive Heart Failure	
__Leg Pains	__Rheumatic Conditions	__Swelling of feet/ankles	
__Shortness of Breath	__Ataxia (Loss of Balance)	__Multiple Sclerosis (MS)	
__Peripheral Arterial Disease		__Peripheral Vascular Disease	
__Psychiatric Disorder:_____		__Cancer:_____	

History of bleeding_____ Are you taking any blood thinners?_____
__Other Major Health Concerns:_____

Social History

1. Do you smoke tobacco? ___Yes ___No
   If Yes: #packs per day?_____ #cigarettes per day?_____ #of years?_____
   If No: Did you ever smoke? ____Yes ____No
2. 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
3. Do you consume alcohol? ____Yes ____No
   If yes, how much?: ____Socially/Rarely ____Occassionally ____Daily ____Recovering
4. 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

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

We participate with most insurance plans. Your insurance policy is a contract that exists between you and your insurance company. If you have questions about your insurance policy and benefits, please contact the phone number on the back of your insurance card.
If we do not participate with your insurance plan, or you do not have your insurance policy information at your visit, payment in full will be required at the time of service. If you do not have your insurance card, you may pay in full and provide the information to our practice within 30 days. We will then issue any necessary credit on the account only after the claim has processed through insurance and explanation of benefits (EOB) is received by our office.
We accept cash, check, credit card (Visa, Mastercard, Discover), Carecredit, and Scratchpay. A $50 fee will be added to your account in the event that a check is returned for insufficient funds.

COPAYS ARE DUE AT THE TIME OF SERVICE.

Medicare: We are a participating Medicare provider. There is no guarantee of service coverage. You are responsible for paying any deductibles, coinsurance, and copayments.

Secondary insurance: Your medical claim will be forwarded to your secondary insurance (if any) after payment and EOB is received from your primary insurance. Please make sure to provide any secondary insurance cards to the front desk 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 company may also deem some medical services unnecessary. It is your responsibility to confirm coverage for services. If you choose to receive these services, you will be responsible for payment.

Self-pay: If you do not have health insurance, payment in full will be due at the time of service**.**

Copayments, deductibles, and coinsurance: All specialist copayments will be collected prior to seeing the doctor. You will be responsible for any deductible and coinsurance amounts. Your insurance company sets these amounts, and failure to collect these amounts is a violation of our contract with them and can be considered fraud.

Referrals: If your insurance plan requires a referral to see a specialist from your primary care provider, it is your responsibility to obtain the referral. Without a referral available, we may need to reschedule your appointment, as your insurance company may not pay the claims.
Billing and Collections: 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 to them. It is your responsibility to comply with your insurance company's request. 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. We will send up to 3 notices for your financial responsibility after the EOB is received from the insurance. After the third notice, your account will be forwarded to a collection agency along with an administrative fee of $50.
Cancellations: A $50 cancellation fee will be added to your account if notice is not provided of the cancellation of your appointment 24-hours in advance and will need to be paid before rescheduling any future appointments.
Surgery Cancellations: Failure to provide 5 business days notice of a cancellation of a surgery scheduled at a hospital or surgery center will incur a $200 fee.
Forms: We charge a $50 fee for the completion of FMLA and disability or similar forms, for each form needing filled.
Privacy Statement: Any information disclosed in your records will remain confidential and will not be used for any reason outside of providing you quality care and treatment. Your information may be used to prior-authorize services or submit claims to your insurance company.

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 have read and agree to the above policies regarding my financial responsibility for services rendered by Columbus Podiatry & Surgery, Inc. and agree to pay any balances unpaid by my insurance plan.

Patient name: _____ Signature_____

Patient's Guardian Name and Signature (If Applicable):
_____

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): _____