Welcome to Our Office

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Social Security #_____

Email Address_____

Driver's License #_____ Marital Status (circle) M S W D

Patient Employed By_____ Occupation_____

Company Address_____ Zip_____ Work Phone #_____

Sex: M / F Injury Date:_____

INSURANCE INFORMATION

Policy Holder's Name_____ Relationship_____

Address_____ Phone_____

Social Security #_____ Date of Birth_____

Primary Insurance_____ Group #_____ ID#_____

Secondary Insurance_____ Group #_____ ID#_____

Medicare #_____ Medicaid # _____

Referred By_____ Phone_____

MEDICARE ASSIGNMENT FOR COVERED SERVICES

I CERTIFY THE INFORMATION GIVEN IN APPLYING FOR PAYMENT IS CORRECT AND REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT TO ED DAVIS, DPM, FACFAS FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE ED DAVIS, DPM, FACFAS TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY ED DAVIS, DPM, FACFAS FOR ANY REASON, I AGREE TO PAY ALL UNPAID BALANCES.

I HAVE READ AND UNDERSTAND MEDICAL PRODUCT DISCLOSURE, MEDICARE ASSIGNMENT, AND ASSIGNMENT OF INSURANCE BENEFITS AND AGREE TO ALL TERMS STATED.

SIGNATURE_____ DATE_____

PATIENT HISTORY FORM

Patient Name_____ Date of Birth_____

Date you are filling out this form_____

Who is the physician or provider referring you to us? Dr._____

What type of complaint or disease is the reason for requesting this visit?

TELL US ABOUT YOURSELF

Home Situation (circle, or add in writing):

Single Married (How long? _____) Divorced (How long? _____) Widowed (How long? _____)

Domestic Partnership Children? yes_____ no_____ Are they healthy? _____

EMPLOYMENT

Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation/type of work/jobs:_____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day? _____

If you have quit, how long ago? _____

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink? _____

If you quit, how long ago? _____

Do family or friends worry about your alcohol intake? _____

MEDICAL HISTORY

Please list other diseases from which you **currently** suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the **past**:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

MEDICATIONS

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

PLEASE LIST ANY DRUG ALLERGIES:

FAMILY HISTORY: Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding
- ☐ history of liver disease or abnormal liver tests

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swelling of ankles or legs, pain, weakness or numbness in:
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General

- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat

- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ blood in urine

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only

- ☐ abnormal Pap smear
- ☐ bleeding between periods

date of last mammogram_____

Men only

- ☐ PSA

Anything else?

- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: If yes, give approximate year given

Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____
Do you use seatbelts?	No_____	Yes_____

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

HIPPA PATIENT QUESTIONNAIRE

Please list family member and/or person, if any, whom we may inform about your general medical condition, your diagnosis and any billing question (including treatment, payment and healthcare operations).

As a reminder, these will be the <u>ONLY</u> people we will be able to speak to or release any information to regarding your account.

Name:_____ Phone:_____

Name:_____ Phone:_____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes_____ or No_____

Please indicate if we may mail your appointment reminder/lab/x-ray results.

Yes_____ or No_____

This form will remain in effect until you make any changes in writing.

_____ _____

Patient Signature Date

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer covers services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.

2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.

3. It is **your** responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately **your** responsibility to verify whether any care you receive is covered by your insurance. With continuous changes in coverage, it is important for **you** to verify **your** benefits and be aware of all restrictions and expenses of **your** plan.

4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments, deductibles and non-covered services at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.

5. For patients owed balances, we will offer payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.

6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.

7. If our doctor is not a contracted provider for your insurance plan, we will file a claim with the information you provide and you will be billed for the entire amount. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.

8. If you do not have a current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card and your social security number.

9. If you have an insurance plan that requires a referral, we will require that the referral be here before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters, it is best for you to contact your primary care physician and have them fax the referral to us or bring the referral in with you.

10. We require that cancellations be made within **24 hours** from your appointment time. There will be a **$25 fee** for no show appointments and late cancellations.

I understand these policies and accept responsibility for payment of my account.

Signature_____Date_____

Printed name_____ Patient Name (if patient is a minor) _____