InStride Myers Podiatry Clinic

## Patient Information

Date _____ SSN_____ DOB _____

Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip Code _____

Home Phone _____Cell # _____ Email _____

Sex: ____ Male ____ Female ____Minor ___Single ____Married ___Divorced ____Widowed ___Separated

Ethnicity: ___Caucasian ___African American ___Asian ____Latino Other _____

Employer _____ Business Phone_____

Emergency Contact _____Phone Number _____

Name of Primary Care Doctor (First/Last Name_____

Phone Number of Primary Doctor _____ Date Last Seen _____

Who may we thank for referring you? _____

## Insurance Information

Primary Insurance Provider _____

Policy Holder Name _____ Sex: ____ Male ____Female

Policy Holder Date of Birth _____ Policy Holder SSN _____

Patient's Relationship to Policy Holder ____Self ____Spouse ____Child ____Other_____

Secondary Insurance Provider _____

Policy Holder Name _____ Sex: Male Female

Policy Holder Date of Birth _____ Policy Holder SSN _____

Patient's Relationship to Policy Holder ____Self ____Spouse ____Child ____Other_____

I, _____ acknowledge that I was provided/offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices.

I hereby authorize payment directly to InStride Myers Podiatry of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or that of my dependents. I understand that I am financially responsible for any collection fee should I default on any patient balances. I authorize the above doctor and/or provider or supplies of services in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

**Signature of Patient or Responsible Party** _____

Date _____

**Medical History and Physical**

Patient's Name_____ Date of Birth_____

Height _____ Weight _____ Shoe Size_____ Pharmacy_____

Phone Number _____

List of Current Medications _____ _____

_____ _____ _____

_____ _____ _____

Allergies – include reaction _____ _____

_____ _____ _____

**Medical History** (check all that apply) ___ No Significant Medical History

___Allergies ___Alzheimer's ___Anemia ____Anxiety ___Arthritis

___Back Pain ___Blood Clots ___Bleeding Problems ___Breathing Problems ___Fibromyalgia

___Cancer (type)_____ ___Circulation Issues ___Depression ___Emphysema

___Diabetes ___Type 1 ____Type 2 ___Gout ___Heart Disease ___Hepatitis

___Heart Murmur ___High Blood Pressure ___High Cholesterol ___HIV ___Kidney Disease

___Liver Disease ___Lymphedema ___Mental Illness ___Neuropathy ___Psoriatic Arthritis

___Rheumatoid Arthritis ____ Stroke ____Restless Leg ____Sleep Apnea ___Skin Disorders

___Ulcer on Feet ____Other (specify)_____

Are you pregnant? ____Yes ____No Are you nursing? ____Yes ____No

**Surgical History** (check all that apply)

____None ____Tonsils/Adenoids ____Angioplasty ____Appendix ____Cataracts

____Colonoscopy ____C-Section ____Gallbladder ____Heart Bypass ____Heart Stent

____Hip Replacement ____Teeth ____Tumor Removal ____Knee Replacement

____Other (specify) _____ _____ _____

Have you had any surgical procedure on your foot or ankle? ____Yes ____No

If yes, please describe _____

_____

Do you have any artificial joints? ____No ____Yes Where? _____

Do you have an artificial heart valve? ____No ____Yes

Have you ever had an adverse reaction to anesthesia? ____No ____Yes

## Social History

Do you drink alcohol? ____No ____Rarely ____Socially ____Everyday

Do you drink caffeinated beverages? ____No ____Yes, how much? _____

What is your occupation? _____

Do you exercise regularly? ____No ____Yes and I do the following type of exercise:

_____

Current or history of substance abuse? ____No ____Yes ____Current ____Past

Please specify if current _____

Do you smoke? ____No ____Yes How long? _____ Packs per Day _____

## Family History (check all that apply and specify relationship)

Patient Name _____ Date of Birth_____

____**Arthritis** ___Mother ___Father ___Sibling

____**Asthma** ___Mother ___Father ___Sibling

____**Blood Clot** __Mother ___Father ___Sibling

____**Cancer** ___Mother ___Father ___Sibling

____**High Blood Pressure** ___Mother ___Father ___Sibling

____**Other** (specify) _____
____Mother ____Father ____Sibling

____**Liver Disease** ___Mother ___Father ___Sibling

____**Bleeding Issues** ___Mother ___Father ___Sibling

____**Heart Disease** ___ Mother ___Father ___Sibling

____**Kidney Disease** ____Mother ___Father ___Sibling

____**Diabetes** ___Mother ___Father ___Sibling
____Type 1 ____Type 2

## Review of Systems

| | | | | |
|---|---|---|---|---|
| Cardiovascular | ___Ankle Swelling<br>___Cold Feet/Hands | ____Leg Pain<br>____Leg Swelling | ____Palpitations<br>____Vascular Disease | ____None |
| Gastrointestinal | ___Abdominal Pain<br>___Blood in Stool<br>___Constipation | ___Decreased Appetite<br>___Diarrhea | ___Heart Burn<br>___Vomiting<br>___Ulcers | ____None |
| | ___Decreased Urination | ___Kidney Stones | ___Painful Urination | |
| Integumentary | ___Athletes Foot<br>___Callus/Corns<br>___Cracked Heels | ___Ingrown Toenail<br>___Keloids<br>___Nail Changes | ___Nail Fungus<br>___Ulcers<br>___Warts | ____None |
| Musculoskeletal | ___Ankle Pain<br>___Arch Pain<br>___Ball Pain | ___Bottom of Foot Pain<br>___Flat Feet | ___Heel Pain<br>___Toe Pain<br>___Top of Foot Pain | ____None |
| Neurological | ___Numbness<br>___Paralysis | ___Seizures<br>___Tingling/Burning | ___Tremors<br>___Weakness | ____None |
| Respiratory | ___Chest Pain<br>___COPD | ___Coughing<br>___Shortness of Breath | ___Wheezing | ____None |

Patient Name _____ Date of Birth_____

What is the reason for you visit? _____

_____

How long have you been having trouble with this issue? _____

What treatments have you tried? _____

What type of pain are you experiencing? ___burning ____constant ___dull ___sharp ___shooting

___throbbing ___tingling ___tearing ___other _____

What makes the pain worse? ___running ___walking ___standing ___certain shoes ___elevation ___touching

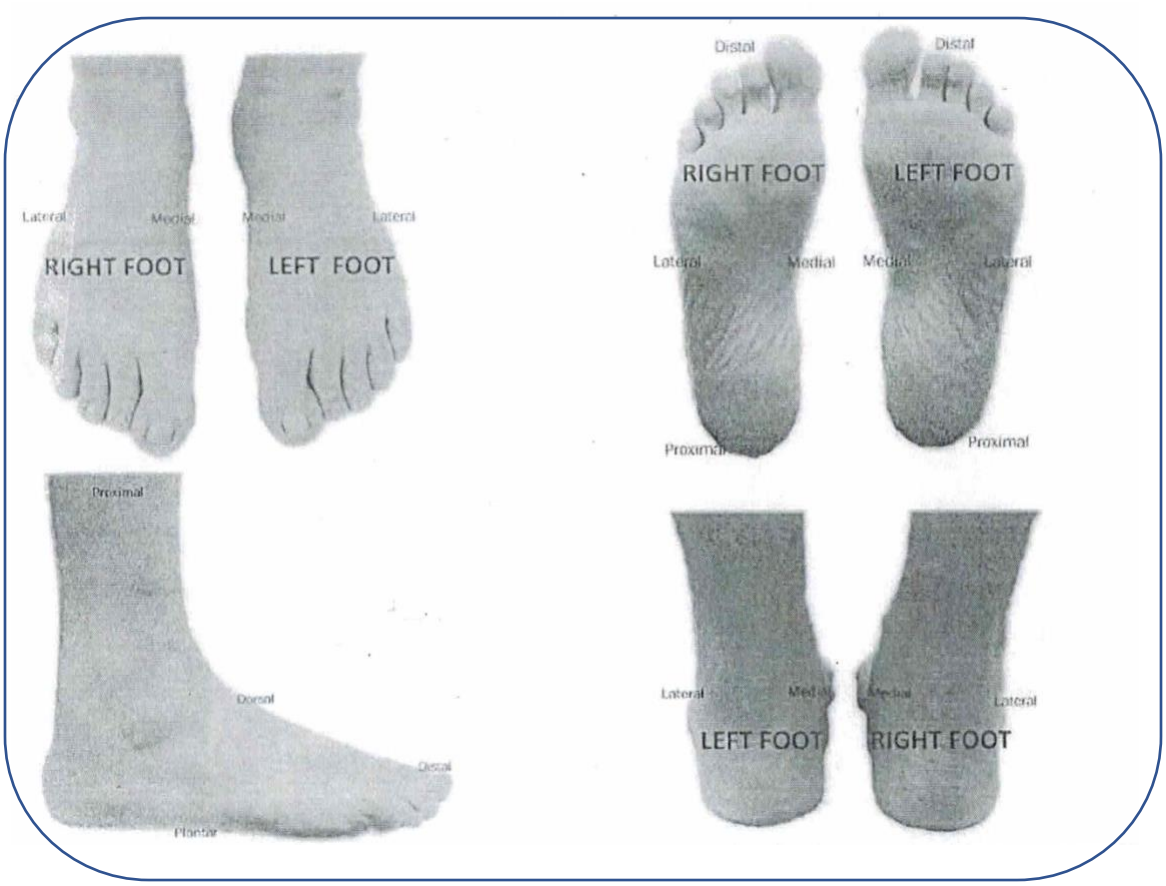
Have you experienced any trauma or injury to the area? ___ Yes ___No If yes, what? _____

_____

Is this condition the result of an event at work? ___Yes ___No If yes, have you notified your employer and the worker's compensation official at your place of employment? ___Yes ___No What is their contact information?

_____

Please indicate by a circle on where on your feet/ankles you are experiencing pain:




The information I have provided 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 any, and all, patient information.

Patient (Patient Representative for Minor) Signature _____ Date_____

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**Documentation for Flu, Pneumonia and Care Plan**

Patient's Name _____ Date _____

**Additional Patient History Information**

1. Have you received a flu vaccination for the current season? ____Yes ____No

If No, what was the reason? ____Patient allergy ____Patient declined ____Vaccine unavailable

2. Have you had a pneumonia vaccination? ____Yes ____No

3. Are you a Diabetic? ____Yes ____No If yes, what was your most recent HBa1C? _____

Name of Physician treating your diabetes _____

4. Has your doctor prescribed medication to treat high blood pressure (hypertension)? ____Yes ____No

Do you smoke? ____Yes ____No

5. Do you have a **Living Will** or someone to make decisions on your behalf? ____Yes ____No

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## Financial Policies

**Payment of Services –** Payment of your bill is considered a part of your treatment. Payment of services rendered is the patient's responsibility. Your insurance policy is a contract between you and your insurance provider. It is YOUR responsibility to give this office correct information regarding your insurance and comply with the conditions of your insurance. Plan eligibility for procedures does not always confirm certification, authorization or payment of service. We will file your primary, and in some cases, secondary insurance claim, but for claims denied and/or procedures not covered by your plan, you will be responsible for paying the amount for service(s). In the event of non-payment and collection or legal fees are incurred, these fees will be added to the collection of balance due.

We accept the following forms of payment: Cash, Personal Check, and VISA, Mastercard, Discover and American Express credit cards. A $30 Return Check Fee will be assessed to your account for any check returned for insufficient funds.

**Co-Payments and Deductibles** – Your insurance provider may require you to pay a co-pay. The co-pay is required at the time of service. If you do not have your co-pay with you at the time of your appointment, we will be happy to reschedule your appointment for the next available opening. The deductible amounts are always the patient's responsibility. Until the deductible is met, your insurance provider is not responsible for reimbursement or payment.

**Missed Appointments** – We request that you give a minimum 24-hour notice if you are not able to make your scheduled appointment time. There will be a $25 charge assessed to your account for two (2) or more missed appointments.

**Surgical Procedure Service Payments** – We will conduct a pre-operative benefit check with your primary insurance provider to determine, as accurately as possible, what your patient responsibility amount will be after insurance. Your estimated part of payment will be required, at minimum, two (2) business days prior to scheduled surgery or surgery will be cancelled. Refunds (when applicable) will be issued on a monthly basis and in the form of a check.

**Non-Covered Services** – Not all insurance plans cover all services that may be needed. In the event your insurance plan determines a service to be "non-covered", you will be responsible for the entire amount. We recognize that some government plans require an "Advance Beneficiary Notice", which we will provide.

**Workers' Compensation Claims** – We file workers' compensation claims, however, your employer must approve treatment and the bill for services rendered must be sent to your employer or its Workers' Compensation provider. If your employer does not approve treatment, and you select to continue with treatment through us, you will be responsible for the bill.

**Lawsuits and Third-Party Billing** – We do not accept Third Party billing. You are responsible for payment of our fees at the time of service unless other arrangements are made in advance.

**No Insurance Coverage** – If you do not have insurance coverage, we expect payment in full before service is rendered. In certain circumstances, payment plans may be made in advance of your visit. If you default on your promised payment, your account may be referred to a collection agency.

**Physician Non-Participation in Your Insurance Plan** – We participate and accept numerous insurance plans. However, there are plans that we do not participate in and you will be responsible for the difference between the "Out of Network" payment and our billed charges. If you have questions concerning this, please contact your insurance plan.

**I am the responsible party for charges incurred for treatment(s) requested and I have read and understand this practice's financial policy and agree to be bound by its terms.**

**Patient's Name _____ Date of Birth _____**

**Signature of Patient (or Responsible Party) _____ Date _____**