New Patient Information

Name:_____

Social Security Number:_____ **Gender:** *Male* *Female*

Birthdate:_____ **Age**: _____ **Email**:_____

Address:_____

Phone#: *House*:_____*Cell*:_____*Work*:_____

Primary Care Physician:_____

Phone #: _____ **Date of Last Visit**:_____

Address (*or Crossroads***):** _____

Emergency Contact & Relationship:_____

Emergency Phone Number (*other than your #):*_____

Marital Status: *Single* *Married* *Separated* *Divorced* *Widowed*

Employment Status: *Employed-Full Time* *Employed-Part Time* *Not Employed*

Employer/School:_____

Pharmacy Name & Location: _____**Pharmacy Phone #:** _____

Who may we thank for referring you*?* _____ **Did your physician refer you*?*** *Yes* *No*

What is the chief complaint for which you came to be treated?

_____

Medications (*please include prescriptions, over-the-counter medications and vitamins*, *and/or attach a separate list*):

_____

Allergies (*pencillin, novocaine, tape, foods, etc*.)**:**

_____

Social History

- ☐ Alcohol Use
- ☐ Current Smoker *Heavy* *Light*
- ☐ Any history of smoking?
  - How long? _____
- ☐ Illegal Drug Use
- ☐ Tobacco Use *Heavy* *Light*
- ☐ **No Alcohol, Tobacco, or Drug Use**

Have you received the influenza vaccination? *Yes* *No* **Month & Year:** _____

65 years or older:

Are you able to name a surrogate decision maker or do you have an advance care plan? *Yes* *No*

Have you received the pneumococcal vaccination? *Yes* *No*

Review of Systems - Check All that Apply

Constitutional
- ☐ Chills
- ☐ Dizziness
- ☐ Fever

Eyes
- ☐ Blurred vision
- ☐ Change in vision

Ear, Nose, Throat, Mouth
- ☐ Swallowing
- ☐ Difficulty hearing
- ☐ Sinus congestion
- ☐ Sore throat

Integumentary
- ☐ Dry, scaly skin
- ☐ Eczema
- ☐ Hypersensitivity of skin
- ☐ Itchy skin
- ☐ Lower leg ulcers
- ☐ Non-healing wound
- ☐ Rash

Respiratory
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Cough
- ☐ Shortness of breath

Musculoskeletal
- ☐ Back pain
- ☐ Decreased range of motion
- ☐ Heel pain
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle tenderness
- ☐ Muscle weakness

Neurological
- ☐ Hypersensitivity
- ☐ Numbness
- ☐ Burning/tingling

Genitourinary
- ☐ Urinary Frequency

Endocrine
- ☐ Decreased hair growth
- ☐ Increased in blood sugar
- ☐ Intolerance to cold/heat
- ☐ Unusual fatigue

Gastrointestinal
- ☐ Abdominal pain/cramping
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Nausea
- ☐ Reflux

Hematologic
- ☐ Environmental/seasonal allergies
- ☐ Gout attack

Cardiovascular
- ☐ Ankle swelling
- ☐ Calf cramping
- ☐ Chest pain/tightness
- ☐ Changes in temperature of extremity
- ☐ Changes in color of extremity
- ☐ Shortness of breath

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Memory loss

Patient Medical History - Check All that Apply

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer – Type: _____
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Other _____
- ☐ Epilepsy
- ☐ Gout
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ **No Medical History**

Family Medical History - Check All that Apply & Circle Mother (M) or Father (F):

- ☐ Allergy **M** **F**
- ☐ Angina **M** **F**
- ☐ Cancer – Type: _____
- ☐ Cardiovascular Disease **M** **F**
- ☐ Dementia **M** **F**
- ☐ Diabetes-Type I **M** **F**
- ☐ Diabetes –Type II **M** **F**
- ☐ Emphysema **M** **F**
- ☐ End-Stage Renal Disease **M** **F**
- ☐ Gestational Diabetes **M** **F**
- ☐ Glaucoma **M** **F**
- ☐ Heart Attack **M** **F**
- ☐ High Cholesterol **M** **F**
- ☐ Hypertension **M** **F**
- ☐ Melanoma **M** **F**
- ☐ Rheumatoid Arthritis **M** **F**
- ☐ **No Family Medical History**
- ☐ **Other** _____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please **Print** name of Patient, Parent, Guardian or Personal Representative Relationship to patient

Insurance Information

Primary Insurance: _____ Who is responsible for this account? _____

Birth Date:_____ Relationship to patient? _____

Secondary Insurance: _____ Who is responsible for this account? _____

Birth Date:_____ Relationship to patient? _____

I certify that I have insurance coverage with the above and assign directly to the doctor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Name (Print)**:** _____

Signature: _____ **Date:** _____

Financial Policy **Please initial next to each policy.*

_____ **No Insurance.** Patients who do not have insurance are expected to pay for all services rendered at the time of service.

_____ **Past Due Accounts.** Patients who fail to make payment arrangements or have not expressed interest in meeting their financial obligations will be turned over to a collection agency. Patients will be required to satisfy their financial obligations to us, and pay for any future services in advance, prior to be seen by our doctors.

_____ **Non-Covered Services.** Medicare or your health insurance company may determine that your visit with our doctors is not "medically necessary" and will deny payment of our services. If this happens, it is your responsibility to pay for our services. We will inform you what services may not be covered by your plan.

____ **Retail/Return Policy.** Full payment of retail items is expected at time of service. We do not accept returns on any of our products.

____ **Missed Appointments.** We charge a $25.00 missed appointment fee with our doctors.

Patient Statement:

I have been informed of the Mission Podiatry PLLC Financial Policy. I have read and understand my obligations. I understand that if Medicare or my health insurance company denies payment, I agree to be personally and fully responsible for payment.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally read the posted Mission Podiatry PLLC Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Please Print Name of Patient: _____

I, _____, hereby authorize the physicians and staff of Mission Podiatry PLLC to give information concerning my health and well-being to the following:

1. _____ _____ _____
   Name Relationship Phone Number
2. _____ _____ _____
   Name Relationship Phone Number
3. _____ _____ _____
   Name Relationship Phone Number

_____ Leave Message on answering machine HOME WORK CELL (please circle)

_____ I DO NOT authorized the release of my medical information.

_____

The following information may be given to the above:
_____ Appointments
_____ Test Results
_____ Medications
_____ Medical History and Treatment

_____ _____ _____
Name Signature Date

If delay in treatment results because we cannot reach you, Mission Podiatry PLLC will not be held responsible.

Do I Need a Test for PAD?

Patients Ages 50 or Older with diabetes, high blood pressure, high cholesterol or are a former or current smoker

Dear Patient,

We want to make sure you are aware of a condition that may affect you. As many as 12 million Americans have Peripheral Arterial Disease (PAD) and many go dangerously unrecognized. It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed due to the buildup of plaque. This is the same disease process that causes blockages of the heart.

Poor circulation may result in the legs when the blood flow becomes sluggish or even blocked. It can result in leg pain or "fatigue", which can limit your physical activity. Having PAD may also increase your risk of a heart attack or stroke if untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would just like more information please do not hesitate to ask.

1. **Do you have a history of, or take medication for any of the following?**

   ☐ Diabetes or "borderline diabetes" ☐ Smoking

   ☐ High Blood Pressure ☐ High Cholesterol

2. **Do you have any discomfort or aching in your legs when you walk that is relieved by rest?**

   ☐ Yes ☐ No

3. **Do your legs ever feel fatigued or heavy when walking or are active?**

   ☐ Yes ☐ No

4. **Do you experience any pain at rest in your lower leg(s) or feet?**

   ☐ Yes ☐ No

5. **Are you bothered at night with burning, pain, or coldness in your feet or toes?**

   ☐ Yes ☐ No

6. **Do you ever need to stop and rest when walking or have difficulty keeping up with others?**

   ☐ Yes ☐ No

7. **Have you noticed any changes in the color or temperature of your feet?**

   ☐ Yes ☐ No

8. **Have you experienced poor healing of wounds or ulcers on your feet?**

   ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Physician Signature: _____ Date: _____