**Henderson Podiatry**

**Date:** ___________________

**Name:** ________________________________________ **Date of Birth:** __________________ **SS #:** ____________________

**Sex:** _ M _F **Marital Status:** _Single _Married _Widowed _Divorced **Email:** __________________________________

**Address:** ___________________________________ **City:** ______________________ **State:** _____ **Zip Code:** __________

**Home #:** ___________________________ **Cell #:** ___________________________ **Other #:** ___________________________

**Emergency Contact Name:** _____________________________________________ **Phone #:** _________________________

**Employer:** _____________________________________________________ **Employer Phone #:** _______________________

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**Primary Insurance:** _____________________________________ **Subscriber Name:** ________________________________

**Relationship to Insured:** Spouse Child Self Other **Sex:** __Male __Female **Date of Birth:** ____________________

*Please circle one*

**Secondary Insurance:** ___________________________________ **Subscriber Name:** _______________________________

**Relationship to Insured:** Spouse Child Self Other **Sex:** Male Female **Date of Birth:** ______________________

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**How did you hear about our practice?** Physician Internet Telephone Book Family/Friend Drive By Other
*Please circle one*

**What is the reason for your visit today?** ___________________________________________________________________

_____________________________________________________________________________________________

**How long has this bothered you?** 1 2 3 4 5 6 7 Days Weeks Months Years

**What treatments have you tried?** __________________________________________________________________________

**Were they effective?** Yes No

**On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain?** __________/10

**The pain quality is:** Burning Constant Dull Sharp Throbbing Tingling

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Telephone Consumer Protection Act (TCPA):
You agree, in order for us to service your account or to collect monies you may owe, Henderson Podiatry, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I have read this disclosure and agree that Henderson Podiatry, its employees and/or agents may contact me as described above.

**Responsible Party Signature:** _________________________________________________ **Date:** ________________________

*The above information 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 updates to the information listed above.*

**Patient Signature:** ____________________________________________________________ **Date:** ______________________

**Date:** ____________________

**Name:** ________________________________________ **Date of Birth:** __________________ **SS #:** ____________________

**Race:** _______________________________ I prefer not to answer **Preferred Language:** ___________________________

*(White, American Indian, Asian, Black or African American, Native Hawaiian, Hispanic, etc.)*

**Pharmacy Name:** ___________________________________________ **Pharmacy Phone:** ___________________________

**Pharmacy Address:** ______________________________________________________________________________________

**Primary Care Physician:** ________________________________________________ **Phone #:** ________________________

**Address:** ________________________________________________________________ **Date Last Seen:** ________________

**Referring Physician (if applicable):** _______________________________________ **Phone #:** ________________________

**Address:** ________________________________________________________________ **Date Last Seen:** ________________

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**Privacy Information Preferences**

Can we call the number on file? Yes No

Can we send mail to the address on file? Yes No

Can we leave a voicemail on the machine? Yes No

Who can we leave messages with? Wife Husband Daughter Son Other: ___________________________________

Will you allow us to send internet based (email) delivery of reminders and newsletters? Yes No

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**Smoking Status**

Current every day smoker

Never smoker

Current some day smoker

I decline to answer

Former Smoker

**Vital Signs**

Blood Pressure: ______/______

Height: ______ Weight: ______

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**Current Medications**

__No known medications __I take the following medications

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

Name: ________________________________________________

*Use the back of this form if more room is needed*

**Allergies**

__No known allergies __No known drug allergies

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

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**PLEASE READ AND SIGN:** The information on my intake form(s) 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 updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA Privacy*): I acknowledge that I have received my HIPAA Privacy Practices Notice. (*Medication History*): I authorize the doctor's office to retrieve my medication history.

**Patient Signature:** ____________________________________________________________ **Date:** _______________________

**Name:** ____________________________________________ **Date of Birth:** ___________________ **SS #:** _____________________

**Medical History:**

| | | | | |
|---|---|---|---|---|
| | Cancer | Diabetes | High Blood Pressure | Polio |
| AIDS/HIV | Cardiac Disease | Edema | Irritable Bowel Syndrome | PVD |
| Alcoholism | Chronic Heart Disease | Emphysema | Kidney Problems | Stroke |
| Arteriosclerosis | Claudication | Fibromyalgia | Lymphedema | Thrombophlebitis |
| Asthma | Congestive Heart Failure | GERD | Osteoporosis | Thyroid Disorder |
| Bronchitis | Crohn's Disease | Gout | Pacemaker | Ulcers |
| | | Hepatitis | Phlebitis | Varicose Veins |
| | | | Pneumonia | None |

**Are you pregnant?** Yes No **Are you nursing?** Yes No

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**Surgical History:** No known surgical procedures

Have you ever had any surgical procedures? Yes No

If yes, please describe: ________________________________________________________________________

**Do you have any artificial joints?** Yes (where? _____________) No **Do you have an artificial heart valve?** Yes No

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**Social History:** Do you smoke? __Yes __No If yes, how many packs per day? ___________ For how long? ___________

Do you drink alcohol? __Yes, everyday (5-7 days a week) __Yes, occasionally/socially __Rarely __No

Substance abuse: No Yes, I have a current substance abuse problem. Please specify: _____________________

**Pneumococcal Vaccine? Yes No Year____** **Advance Care Plan, Living Will? Yes No**

What is your occupation? ______________________________ Does it involve mostly: __standing or __sitting

Do you exercise regularly? No Yes, I do the following exercises: _____________________________

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**Family History:** Is there any family history (blood relative)

Blood Clot: ____________________________________________

Circulation Problems: ____________________________________

Diabetes/Type: _________________________________________

Heart Disease: ______________________________

High Blood Pressure: _________________________

Neurological: _______________________________

Strokes: ___________________________________

Other: ____________________________________________________________________________________________

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**Review of Systems:** *Please circle any symptoms you are currently experiencing, or circle NONE if applicable*

| | | |
|---|---|---|
| **Cardiovascular** | ankle swelling, color change in extremity, high blood pressure, leg cramping, pacemaker, shortness of breath, temperature change in extremity, varicose veins | NONE |
| **Genitourinary** | blood in urine, burning with urination, decreased urination, excessive urination, incontinence, inability to urinate, kidney dialysis, need to get up during the night to urinate | NONE |
| **Gastrointestinal** | abdominal pain, constipation, diarrhea, heartburn, vomiting, yellowing of skin | NONE |
| **Integumentary** | athlete's foot, dry, scaly skin, itchy skin, numbness, rash, tingling, ulcers | NONE |
| **Hematologic** | anemia, blood thinner, bruise easily, clotting disorder, swollen glands | NONE |
| **Musculoskeletal** | back pain, decreased flexibility, difficulty walking, foot pain, heel pain, hip pain, joint pain, joint swelling, leg cramps, morning stiffness | NONE |
| **Respiratory** | asthma, chest pain when inhaling, coughing up excess sputum, difficulty breathing, shortness of breath, sleep apnea, wheezing, frequent cough | NONE |
| **Endocrine** | blood sugar is high, blood sugar is low, delayed wound healing, dry skin, excessive thirst, hair loss, too hot, too cold, tired/sluggish | NONE |
| **Constitutional Symptoms** | appetite decreased, appetite increased, chills, dizziness, fever, headache, cough, nausea and vomiting, thirst, tiredness, weight gain, weight loss (unintentional) | NONE |
| **Eyes, Ears, Nose Mouth & Throat** | blurred vision, cough, difficulty hearing, ears ringing, dry mouth, loss of vision, post-nasal drip, congestion, drainage, difficulty swallowing, light sensitivity | NONE |

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**PLEASE READ AND SIGN:** The above information 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 updates to the information listed above.

**Patient Signature:** ________________________________________________ **Date:** ___________________

# HENDERSON PODIATRY FINANCIAL POLICY

Dr. Henderson and office staff are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. Please read and sign below.

Please make sure to bring all current health insurance cards and a valid form of ID to each visit and inform the receptionist of any changes, including new address, telephone numbers, insurance, or employment changes.

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE.** Any co-payments, co-insurance, deductibles, **non-covered charges**, or outstanding balances will be due at the time of your visit. We gladly accept cash, check, Visa, MasterCard, and American Express. We will bill participating insurance companies as a courtesy to you. If you do not carry insurance, payment in full is expected at the time of your visit.

Due to many different insurance products out there, our staff cannot guarantee your eligibility and coverage. You are responsible for contacting your member benefits department about services and physicians prior to your appointment. **Patients with HMO insurance policies must have a valid referral** and it is the patient's responsibility to contact his/her Primary Care Physician to obtain one. If a valid referral is not present at your scheduled appointment time, we will need to reschedule your visit. **Not all insurance plans cover all services. If your insurance plan determines a service to be "non-covered," you will be responsible for the complete charge and payment is due upon receipt of a statement from our office.**

We know that sometimes financial problems occur. Payment plans may be made with the billing department on a case-by-case basis and will be set up for automatic credit card payments. Payment plans may be set up for weekly or monthly payments and *must be paid in full within 3 months.* **This does not include laser treatment which is always fee-for-service due at the time of visit.**

**Missed Appointments/Late Cancellations:** Broken appointments represent a cost to us, to you, and to other patients who could have been seen at the time reserved for you. We kindly request at least 24 hours advance notice for cancellations. We reserve the right to charge a $48 fee for missed or late-cancelled appointments.

Any bill not paid by the date it is due may be turned over to an outside collection agency or the attorney for the unpaid amount. The patient will be responsible for all fees and costs that are charged by the agency or attorney. Any check returned by the bank will be charged a $25 returned check fee.

**I have read, understand, and agree to the Henderson Podiatry Financial Policy above.**

Patient's Signature: ______________________________________________________

**Insurance Authorization**

I authorize the release of the medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

Patient's Signature: ______________________________________________________

I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature: ______________________________________________________