

PATIENT INFORMATION

Full Name _____
 DOB _____ / _____ / _____ Age _____ Male Female
 Address _____
 City/State/Zip _____
 Cell Phone _____ Home Phone _____

Which you prefer to be called on first: () Cell () Home

Email _____

Ethnicity: NOT Hispanic or Latino Hispanic or Latino Decline

Primary language: English Spanish Other _____

Race: White Native Hawaiian or Pacific Islander Asian Black or African American American Indian Decline

Marital Status: Married Single Widowed Divorced

Employer _____ Occupation _____

HOW DID YOU HEAR ABOUT US?

Friend Google Doctor Referral Yelp Insurance Internet Other _____

Family physician: _____ Phone# _____ Last seen: _____

Doctor who treats your Diabetes (if diabetic) : _____ Last seen: _____

Emergency Contact _____ Phone _____ Relationship: _____

Pharmacy _____ Address _____ City _____

My Preferred method of communication in regards to my medical condition

- 1.) How can we contact you? (check ALL that apply) Phone Mail Email Text message
- 2.) **If the above method of communication is by phone, please check the appropriate box below (check one):**
 - Leave a message with detailed information.
 - Leave a message with a call-back number only.
- 3.) Okay to leave message with: Self Only Patient and/or spouse Anyone answering phone
- 4.) Whom may we release medical information to: _____

INSURANCE INFORMATION:

PRIMARY Insurance Name	Member ID #:
Policy Holder Name & Birthday	DOB: / /
Policy Holder Employer	

SECONDARY Ins. Name	Member ID #:
Policy Holder Name & Birthday	DOB: / /

Notification of Changes

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

X _____ DATE _____
 Patient's Signature or Parent/ Legal Guardian

MEDICAL HISTORY

PATIENT NAME: _____

State in your own words your medical reason(s) for coming into our office:

FOR WOMEN ONLY: ARE YOU PREGNANT? _____ IF SO HOW MANY MONTHS? _____

Is this visit related to an injury at work? (___) Yes (___) No

Shoe Size: _____ **Are you a current smoker? Yes No**

MEDICATIONS- Please list all medications that you currently use:

ALLERGIES- Are you allergic to or have you ever reacted to any of the following?

Yes	No	Aspirin	Yes	No	Lidocaine (local anesthesia)
Yes	No	Band-aids/ tape	Yes	No	Sulfa drugs
Yes	No	Latex	Yes	No	Penicillin
Yes	No	Steroids	Other: _____		

YOUR Past Medical History: Have YOU ever HAD or HAVE any of the following? CHECK ALL THAT APPLY

<p>Eyes : <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma</p> <p>ENTM : <input type="checkbox"/> Trouble Hearing</p> <p>Integumentary: <input type="checkbox"/> Eczema <input type="checkbox"/> Odor <input type="checkbox"/> Sweaty feet</p> <p>Allergies: <input type="checkbox"/> Seasonal Allergies</p> <p>Musculoskeletal : <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis</p> <p>Neurological: <input type="checkbox"/> Cramping (legs or feet) <input type="checkbox"/> Numbness (legs or feet) <input type="checkbox"/> Tingling (legs or feet) <input type="checkbox"/> Burning (legs or feet) <input type="checkbox"/> Seizure</p> <p>Social: <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Abuse</p>	<p>Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> COPD</p> <p>GI: <input type="checkbox"/> GERD <input type="checkbox"/> Stomach ulcers</p> <p>CVS: <input type="checkbox"/> Stroke <input type="checkbox"/> Kidney disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure</p> <p>Endocrine: <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Anemia</p> <p>Psychiatry: <input type="checkbox"/> Depressed <input type="checkbox"/> Anxiety</p> <p>Immunology: <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS</p> <p>(___) NONE OF THE ABOVE</p>
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FAMILY Past Medical History: Circle ALL that apply

Father:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown
Mother:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown

X _____
Patient's Signature or Parent/ Legal Guardian

Date

OFFICE POLICIES

PATIENT NAME: _____

Authorization for Insurance to Pay

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Trinity Foot Center, PC, the office of Lisa J. Brandy, DPM. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and products sold through Trinity Foot Center, PC.

I authorize the above named provider to release to the Social Security Administration or its intermediaries any information needed for the claim or related medical claim. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance program.

Non-Covered Services

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

Products and DME Supplies

All over-the-counter products purchased are non-refundable. All durable medical equipment (DME) such as ankle/foot braces, shoes, and walking boots, etc. are non-refundable once dispensed.

Surgery

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of "surgery", meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

Appointments

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a \$25 fee for each no show occurrence.**

Prescription Refills

Prescription refills or change requests will be handled within 24 hours of the receipt of the request during regular office hours. Please contact your pharmacy so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

Notice of Privacy Practices

Our office follows all HIPAA and Privacy Practice Acts as required by law. The privacy practice notice is posted in our lobby. Upon request, you will be provided a copy in paper or electronic form. I have read (or had the opportunity to read, if I so chose) and understood the notice.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X _____ Date _____
Patient's Signature or Parent/ Legal Guardian