



Community Foot Specialists

(937)426-9500 ♦ (937)322-7607 (Springfield)

5925 N. Main St., Suite D, Dayton ♦ 2207 Olympic St., Springfield ♦ 3359 Kemp Rd., Suite 230, Beavercreek

1 Elizabeth Place, Dayton ♦ 1 E. National Rd., Suite 300, Vandalia ♦ 275 N. Main St., Ste. A, Springboro

Patient Information

Name: _____ Date of Birth: _____ Age*: _____

Address: _____ City, State: _____ Zip: _____

Primary Phone Number: _____ Home Cell Work

Secondary Phone Number: _____ Home Cell Work

SSN: _____ Email: _____

Shoe Size: _____

Height: _____ Weight: _____

Gender: M F Marital Status: Single Married Divorced Separated Widowed

Employer: _____ Patient Occupation: _____

Employer Address: _____ Employer Phone: _____

*If patient is under 18, we will need the following information from a parent or guardian:

Name: _____ Date of Birth: _____ SSN: _____

Relationship to Patient: _____ Phone (if different from patient): _____

Address (if different from patient): _____

Referral Information

Who may we thank for referring you?

Physician _____

Insurance Plan _____

Family/Friend _____

Yellow Pages AT&T Google Internet

DaytonFeet.com Walked By/ Drove By

Former Patient

Other _____

Primary Care Physician

To facilitate sharing of information related to your care, please provide the following information.

Primary physician _____

Office Phone Number _____

Date of Last Visit? (approx) _____

Do You Reside in Hospice? Yes No

Do You Reside in a Nursing Home? Yes No

Name of Residence: _____

Insurance Information

Primary Insurance Name: _____ Identification #: _____

Group #: _____ Who is Responsible for this Account? Self Spouse Parent

Cardholder Info: Name: _____ Date of Birth: _____ SSN: _____

Secondary Insurance Name: _____ Identification #: _____

Group #: _____ Who is Responsible for this Account? Self Spouse Parent

Cardholder Info: Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact

Name: _____ Relationship: _____

Primary Phone Number: _____ Home Cell Work

Secondary Phone Number: _____ Home Cell Work

What Brought You in Today?

What is the reason for your visit today? (Indicate foot, ankle, toe, etc.)

When is it problematic?: _____ What makes it better/worse?: _____

How have you treated it? _____

Have you ever been to a podiatrist? Yes No If yes, please list the podiatrist: _____

Podiatric History - Please indicate your current and past foot problems:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Frequent Ankle Sprains | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Tired Feet |
| <input type="checkbox"/> Athlete's Foot/Foot Fungus | <input type="checkbox"/> Gout | <input type="checkbox"/> Plantar Warts | <input type="checkbox"/> Weakness of Legs or Feet |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Thick, Discolored Toenails | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Corns and Calluses | <input type="checkbox"/> High Arch | <input type="checkbox"/> Recurrent Foot/Leg Wounds | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Curly Toes/Hammer Toes | <input type="checkbox"/> Ingrown Nails | <input type="checkbox"/> Shooting/Aching Foot Pain | _____ |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Swelling in Ankles or Feet | _____ |

Lifestyle

What is your activity level? Not active Somewhat active Moderately active Highly Active

Do you exercise/participate in athletic activities? Yes No | Do you smoke/ use tobacco? Yes No

What activities do you participate in and how frequently? _____ | Do you drink alcohol? Yes No

Do you travel frequently? Yes No | Do you drink coffee/other caffeinated drinks? Yes No

Do you use recreational drugs? Yes No

Allergies - Please list any and all allergies that you have. Check none if you have no known allergies:

- | | | | | |
|--|----------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Seafood | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Demerol | <input type="checkbox"/> Novocain | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Bee or Insect Stings | _____ |

Please indicate the severity of your reaction to each allergy indicated above (severe, mild, etc.): _____

What happens with each allergic reaction? (skin rash, breathing problems, stomach ailments, etc.) _____

Medical History - Please indicate if you have had any of the following conditions:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Valves or Joints | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Weight Loss, unexplained |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Phlebitis | _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | _____ |

Medications - Please list all medications taken (unless you have provided a separate list)

- I brought a list and gave it to the front desk I take oral contraceptives I take blood thinners/anti-coagulants

Pharmacy Name: _____ Pharmacy Number: _____

Surgeries and Hospitalizations - Please list all surgeries that you have had: _____

Please list any other hospitalization(s) that were not for the surgeries listed (if any): _____

Other Health Issues - Is there anything else you would like to share with your doctor regarding your health or medications that is not covered above? _____

Assignment & Release

Commercial Insurance Authorization

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and sign directly to Community Foot Specialists 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 hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Community Foot Specialists for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release for the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, 20%, and non-covered services. Coinsurance, 20% and the deductible are based upon the charge determination of the Medicare carrier.

Signature of patient or responsible party if patient is under 18

Date

Consent - I certify that the above information is true and correct to the best of my knowledge. 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 conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

Signature of patient or responsible party if patient is under 18

Date

FOR OFFICE USE

Reviewed by: _____ Date: _____



Community Foot Specialists

Payment Policy & Privacy Practices

Notice of Privacy Practice

Health Information Use and Disclosure. Community Foot Specialists understands that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information expressly for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except for the aforementioned reasons, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notices in effect in our facility.

Additional Disclosure Authority. In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below. This can include: any/all members of immediate family, spouse, employer, school, or any other person.

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Patient Rights

As our patient, you have the following rights:

- ◆ To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
- ◆ To receive an accounting of certain health information disclosures we have made.
- ◆ To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
- ◆ To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- ◆ To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete. To receive notice of our privacy practices by requesting a paper copy at any time.

Acknowledgement of Payment Policy/Notice of Privacy Practices

Payment Policy

I have read and fully understand the payment policy of Community Foot Specialists. I acknowledge my rights and responsibilities and agree to act in accordance with the policy set forth. I understand that if I fail to comply with the policy, Community Foot Specialists reserves the right to dismiss me from the practice.

Privacy Practices

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

Signature of patient or responsible party if patient is under 18

Date