



# PATIENT INFORMATION FORM

Type to enter info, print and sign, and bring to your visit.

**First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_  
**Date of Birth (DOB):** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender (M,F, Other):** \_\_\_\_\_  
 (mm/dd/yyyy)

**Social Security No.:** \_\_\_\_\_ **Driver License (DL) #:** \_\_\_\_\_ **DL State:** \_\_\_\_\_  
**Mailing Addr:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Phone (Home):** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_  
 (Single, Married, Divorced, Widowed)

**Ethnicity:** Are you Hispanic or Latino (Yes or No)? \_\_\_\_\_  
 American Indian or Alaskan Native  Native Hawaiian/Other Pacific Islander   
 Asian  White   
 Black or African American  Other

**Employment Status:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
 (FT, PT, Not Employed)

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_

**How Were You Referred to Us?** \_\_\_\_\_  
 (Website, Existing Patient, Friend or Relative, Dr. Referral, Insurance Referral, Other -Please Describe)

**Legal Representative/Responsible Party:** **Name:** \_\_\_\_\_  
 (Who is responsible for the bill, if other than the patient?) **DOB:** \_\_\_\_\_  
 If patient is responsible, put "Self" (for Name) **Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_

**PRIMARY Insurance:** **Insurance Name:** \_\_\_\_\_  
**Cardholder Name:** \_\_\_\_\_  
**ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**Insured Date of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
 (If different from patient) (mm/dd/yyyy) (If different from patient)

**SECONDARY Insurance:** **Insurance Name:** \_\_\_\_\_  
**Cardholder Name:** \_\_\_\_\_  
**ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**Insured Date of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
 (If different from patient) (mm/dd/yyyy) (If different from patient)



Diagnostic Foot Specialists  
**PATIENT HISTORY FORM**

PHF-2021-V1

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_  
(mm/dd/yyyy)

Primary Care Dr.: \_\_\_\_\_

City/State: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Last Office Visit Date: \_\_\_\_\_  
(mm/dd/yyyy)

**Diabetic Care**

Are You a Diabetic?  
(Answer Yes or No): \_\_\_\_\_

(If Yes) Is your HbA1c Level (Check 1):

Greater than 9

Less than 7

Between 7 and 9

Level Check Not Performed

Diabetic Care Dr.: \_\_\_\_\_

City/State: \_\_\_\_\_

Office Phone No.: \_\_\_\_\_

Last Office Visit Date: \_\_\_\_\_  
(mm/dd/yyyy)

Preferred Pharmacy  
& Address: \_\_\_\_\_  
Street Address, City, State, Zip Code

Height: \_\_\_\_\_      Weight: \_\_\_\_\_  
Ft. and Inches      Lbs.

Shoe Size & Width: \_\_\_\_\_

Current Medications and Vitamins: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Allergies to Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

(Check All That Apply)

Diabetics, complete **Diabetic Care** section (above)

- |                          |                      |                          |                       |
|--------------------------|----------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | Arthritis            | <input type="checkbox"/> | Neurological Disorder |
| <input type="checkbox"/> | Autoimmune Condition | <input type="checkbox"/> | Neuropathy            |
| <input type="checkbox"/> | Bleeding Disorder    | <input type="checkbox"/> | Stroke                |
| <input type="checkbox"/> | Cancer               | <input type="checkbox"/> | Other _____           |
| <input type="checkbox"/> | Circulatory Problems |                          |                       |
| <input type="checkbox"/> | Gout                 |                          |                       |
| <input type="checkbox"/> | Heart Disease        |                          |                       |
| <input type="checkbox"/> | Hepatitis            |                          |                       |
| <input type="checkbox"/> | High Blood Pressure  |                          |                       |
| <input type="checkbox"/> | High Cholesterol     |                          |                       |
| <input type="checkbox"/> | HIV / AIDS           |                          |                       |
| <input type="checkbox"/> | Kidney Disease       |                          |                       |



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**PATIENT HISTORY FORM**

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**Surgical History:**

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**Social History:**  
(Check All That Apply)

Tobacco Use  
(If Yes, Indicate Light/Heavy Use, Current or Former User)

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Alcohol Use  
(If Yes, Indicate Light/Heavy Use, Current or Former User)

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Caffeine Use  
(If Yes, Indicate Light/Heavy Use, Current or Former User)

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Drug Use  
(If Yes, Indicate Light/Heavy Use, Current or Former User)

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**Family History:**  
(Mother/Father Only, Check All That Apply)

- No Known Family Medical History
- Bleeding Disorder
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Stroke
- Other Issues \_\_\_\_\_

**Patients Aged 65 and Older**

Please answer **Y** (Yes) or **N** (N) for all questions in this section.

- Fallen in the past **six (6) months**?  
(If Y) How many? \_\_\_\_\_
- Experienced any changes, issues with **vision**?
- Experienced any issues with **heart rate or heart rhythm**?
- Experienced any issues with incontinence?



Reason for Today's Visit?

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy) Doctor: \_\_\_\_\_

Please check the conditions that you are currently experiencing, as well as previously-experienced conditions.

<b>Constitutional</b>	<input type="checkbox"/> Chills	<input type="checkbox"/> Fever	<input type="checkbox"/> Sweats	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Weight Loss			
<b>Eyes</b>	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Contacts	<input type="checkbox"/> Double Vision	
	<input type="checkbox"/> Eye Glasses	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	
	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> None Apply		
<b>Ear/Nose/Throat/Mouth</b>	<input type="checkbox"/> Dentures	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nose Bleeds	
	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Sore Throat		
<b>Cardiovascular</b>	<input type="checkbox"/> Cardiovascular Surgery	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Circulatory Disease	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Leg Pain (w/ Exercise)	<input type="checkbox"/> Pace Maker	
	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling (Legs & Ankles)		
<b>Hematologic</b>	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Abnormalities	<input type="checkbox"/> Blood Clots (Previous)	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Lump (Groin or Armpit)	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Swollen Glands	
<b>Respiratory</b>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Coughing	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Pulmonary Disease	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Tuberculosis	
	<input type="checkbox"/> Wheezing			
<b>Gastrointestinal</b>	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Constipation	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hepatitis	
	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Vomiting		
<b>Endocrine</b>	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Often Urinating	
	<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Prostate Problems	
	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> None Apply		
<b>Musculoskeletal</b>	<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Bursitis	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Feeling Weak	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Tendonitis	
	<input type="checkbox"/> Weakness in Limbs			
<b>Neurologic</b>	<input type="checkbox"/> Aphasia (Loss of Speech)	<input type="checkbox"/> Ataxia (Loss of Balance)	<input type="checkbox"/> Confusion	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Migraines	<input type="checkbox"/> Neuropathy (Sensation Loss)	
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Stroke	
<b>Integumentary</b>	<input type="checkbox"/> Change in Skin Color	<input type="checkbox"/> Cracking of Skin	<input type="checkbox"/> Eczema	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Growth on Skin	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Keloid	
	<input type="checkbox"/> Lesions	<input type="checkbox"/> Rash	<input type="checkbox"/> Recurrent Infections	
	<input type="checkbox"/> Sensitivity to Sun	<input type="checkbox"/> Skin Ulcers		
<b>Psychological</b>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Nervousness	<input type="checkbox"/> None Apply
	<input type="checkbox"/> Tension			

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

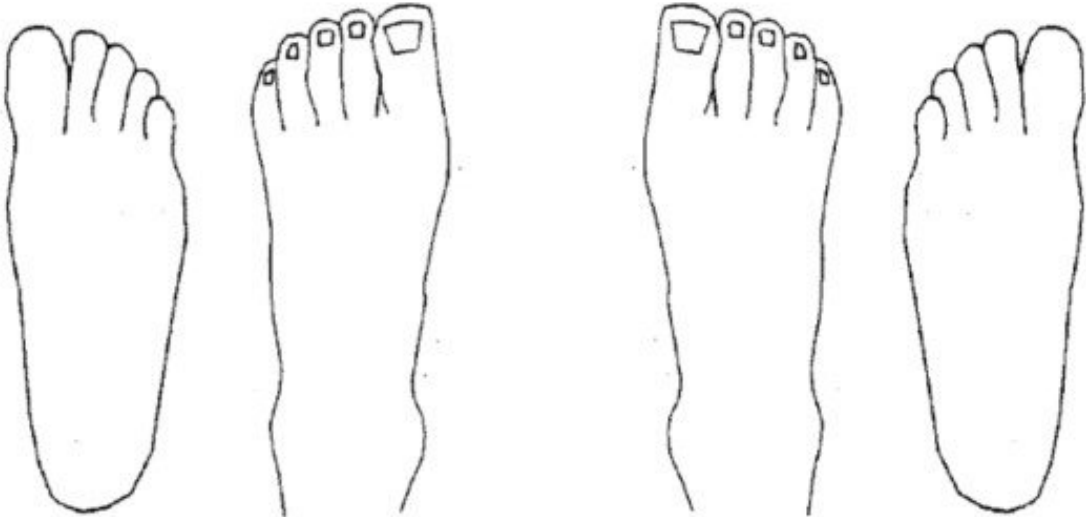
(mm/dd/yyyy)

# Pain/Discomfort Location Indicator

Please mark (with an X) the area or areas where you are experiencing pain or discomfort.

Left foot

Right foot



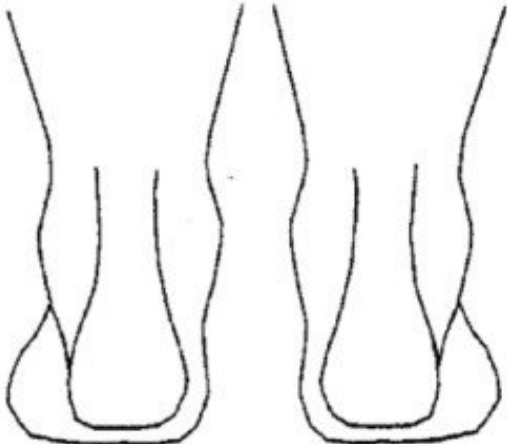
Sole / bottom

Top

Top

Sole / bottom

Ankles (back view)



Left

Right

## CONSENT FOR TREATMENT

I hereby give permission to Diagnostic Foot Specialists (DFS or Practice) to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. DFS is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, **I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Signature of Patient or Legal Guardian (mm/dd/yyyy)

## PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

### I. Acknowledgement of Practice's Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP). I have read and/or was given the opportunity to read if I so chose and understood the Notice and agree to its terms. *\*\*Notice of Privacy Practice is available at the front window upon request\*\**

\_\_\_\_\_  
Name of Patient (Please Print) Date of Birth \_\_\_\_\_  
\_\_\_\_\_  
Signature of Patient/Parent/Guardian Date (mm/dd/yyyy) \_\_\_\_\_

### II. Designation of Certain Relatives, Close Friends & Other Caregivers as my Personal Representative

I agree that the practice may disclose certain health information to a personal representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the practice will disclose only information that is directly relevant for the person's involvement with my healthcare and/or payment relating to my healthcare.

Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_

### III. Request to Receive Confidential Communications by Alternate Means

I authorize the practice to communicate with me in confidence about my protected health information by the alternative means that I have listed below, upon request.

**Home Telephone Number:** \_\_\_\_\_ **Cell Phone Number:** \_\_\_\_\_  
\_\_\_\_ OK to leave message with detailed information \_\_\_\_\_ OK to leave message with detailed information  
\_\_\_\_ Leave message with call back numbers only \_\_\_\_\_ Leave message with call back numbers only

**Written Communication Address:** \_\_\_\_\_  
\_\_\_\_ OK to mail to address listed above  
\_\_\_\_ OK to email me at: \_\_\_\_\_

**Text Communication:** \_\_\_\_\_  
\_\_\_\_ OK to send a secure, HIPAA-compliant text message to the cell phone number listed above

**Other:** \_\_\_\_\_

\_\_\_\_\_  
Name of Patient (Please Print) Date of Birth (mm/dd/yyyy)  
\_\_\_\_\_  
Signature of Patient/Parent/Guardian Date (mm/dd/yyyy)

## FINANCIAL POLICY FOR Diagnostic Foot Specialists, PC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. All insurance information must be provided to our office at the time of service.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if applicable) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If payment is not received from your secondary insurance within 45 days the balance becomes your responsibility.

**COINSURANCES/COPAYMENTS AND DEDUCTIBLES:** All coinsurances, copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent up to three (3) notices/statements of your financial responsibility (copay/coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. **We accept the following payment methods: Cash, Credit, or FSA/HSA cards. Personal checks are not accepted.** ~~An additional \$25.00 will be added to your statement if the check is returned for insufficient funds.~~ In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Diagnostic Foot Specialists, PC for medical services provided. I agree to pay Diagnostic Foot Specialists, PC any balance unpaid by my insurance carrier for myself or the below named person.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

### Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Diagnostic Foot Specialists, PC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, coinsurances and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance.

PRINT Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

### FINANCIALLY RESPONSIBLE PARTY (If not the patient)

PRINT Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_