PLEASE FILL OUT COMPLETELY **TODAYS DATE_____**

Patients full name:

Last_____ First_____ MI___ SEX M F

Patients SSN _____ Date of Birth _____

Marital Status S M D W Name of Spouse _____

E-Mail _____

Address _____

City _____ State _____ Zip Code_____

Primary Phone _____ Work_____ Cell_____

Employers' Name _____ Job Title _____

Company Phone _____ Address_____

How did you hear about us?_____ If referred, by whom? _____

Name AND Relationship of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician _____ Date last seen _____

Phone _____ Fax _____Address _____

Name of Pharmacy :_____ Phone number_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

Person responsible for services rendered if different than listed above

Name_____ SSN _____ DOB _____

Insurance name _____ Policy number_____

HEALTH QUESTIONARE

PATIENTS NAME: _____ HEIGHT_____ WEIGHT_____ SHOE SIZE_____

TYPE OF FOOT PROBLEM _____

HOW LONG HAS IT BEEN A PROBLEM? _____

HAVE YOU HAD ANY PREVIOUS TREATMENT? _____

HISTORY OF YOUR PAST ILLNESSES: IF ANSWERING YES, PLEASE EXPLAIN BELOW:

ARTHRITIS OR BURSITIS	**NO**	**YES**	_____
ANEMIA	**NO**	**YES**	_____
BACK PROBLEMS	**NO**	**YES**	_____
DIABETES	**NO**	**YES**	_____
STROKES	**NO**	**YES**	_____
CANCER	**NO**	**YES**	_____
THYROID	**NO**	**YES**	_____
STOMACH ULCERS	**NO**	**YES**	_____
HEPATITIS/LIVER	**NO**	**YES**	_____
HIV/ AIDS	**NO**	**YES**	_____
ASTHMA/RESPIRATORY	**NO**	**YES**	_____
HIGH BLOOD PRESSURE	**NO**	**YES**	_____
BLEEDING DISORDER	**NO**	**YES**	_____
HEAD INJURIES	**NO**	**YES**	_____
ELEVATED CHOLESTEROL	**NO**	**YES**	_____
HEART DISEASE	**NO**	**YES**	_____

SURGERIES:

_____

ALCOHOLIC BEVERAGES: NEVER RARELY MODERATELY

TABACCO: NO /YES: ___PACKS PER DAY FOR ____YEARS FORMER SMOKER: NO YES

FLU SHOT: NO YES: MONTH/YEAR _____

MEDICATIONS:

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

_____

PATIENT RECORD FOR DISCLOUSERS

In general, the HIPPA privacy rule is given individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office

I wish to be contacted in the following manner (check all that applies):

___Home Telephone _____

___O.K. to leave message with detailed information

___ Leave message with call-back number only

___ Written communication

___ O.K. to mail to my home address

___ O.K. to mail to my work/office address

____ Work Telephone _____

____ O.K to leave message with detailed information

____ Leave message with call back number only

____ Other _____

____ Other: _____

Patient Signature: _____ Date: _____

Print Name: _____ Date: _____

The Privacy Rule generally requires healthcare to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Precision Foot and Ankle Centers

Name_____ Date_____

Initials OUR FINANCIAL POLICY

___1. I understand that I am ultimately responsible for my account in full, even though I have medical insurance. Should there be a problem with my insurance company not paying in a timely manner, or for the correct amount, I agree to pay the doctor and settle my differences with my insurance company.

___2. I understand that Precision Foot and Ankle Centers accepts Master Card/Visa, personal checks, money orders or cash. If the bank returns my check as "un-payable", I will be charged a $25.00 service fee which will be due and payable within three (3) days along with the amount of the original check.

___3. I understand that if I receive a statement in the mail, the amount stating my responsibility is due in 10 days.

___4. If my account exceeds 90 days, I understand that I am in a collection status, and a finance charge equal to 1 ½ percent per month will be added to my account.

MEDICAL INSURANCE POLICY

___1. I understand that I am required to pay for all charges on the date services are rendered unless I am covered by a health plan which the physician accepts, and I am being seen for a service I know to be covered by my policy.

___2. I will pay all co-pays, deductibles or percentages due by the date of service. If not collected, I am still responsible to pay.

___3. I hereby authorize payment to the physician or Eric M. Feit, DPM, Inc. insurance benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as valid as the original.

___4. I hereby authorize the disclosure of my medical information to my stated insurance company for the purpose of obtaining payment for services rendered.

Signature: _____ Date: _____