BEVERLY PODIATRY

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PATIENT INFORMATION SHEET – CONFIDENTIAL

Name _____ Sex _____ Date of Birth _____ Age _____

Street _____ Home Phone _____

Town/City _____ State _____ Zip Code _____

Social Security # _____ Name of (Spouse/Partner/Parent) _____
Circle One

Employer (Self) _____ Work Phone _____ Cell Phone _____

Responsible Party _____ Billing address _____
(If Different from above)

Can we leave a message at your home? ❒ Yes ❒ No

Pharmacy Information

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone # _____

Pharmacy Fax # _____

Physician Information

Primary Physician _____

Primary Physician Address _____

Phone # _____

Fax # _____

Last Physician's Visit _____

Patient Consent for Extended Authorization and Treatment

1) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility, as the patient or guardian, to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however, you the patient or guardian are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you, the patient or subscriber, and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any services rendered will become the responsibility of the patient.
2) I hereby authorize Beverly Podiatry, Inc. to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to Beverly Podiatry, Inc. all payments for medical services rendered to myself or my dependents. I am aware that **it is my obligation to know my insurance company's policies** and that I am responsible for payment.
3) If requested, I will be provided a copy of the Notice of Privacy Practices and I have read or had the opportunity to read and I understand.

Signature _____ Date: _____
(Parent, if patient is a minor)

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Beverly Podiatry, Inc. and its designees.

Signature: _____ Date: _____
(Parent, if patient is a minor)

NAME _____

BEVERLY PODIATRY AUTHORIZATIONS SIGNATURE PAGE*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize the release of any medical or other information necessary to process my insurance claim(s). I also authorize payment of my insurance and/or Government Benefits be made directly to Beverly Podiatry which include but not limited to Tim Tobin, DPM, Lawrence McGuiness, DPM and Kenneth Cesa, DPM whom accept assignments.

Signature _____ Date _____

NON-COVERED SERVICES WAIVER/NOTICE OF FINANCIAL LIABILITY

I accept full financial liability for all items or services which are determined by my health care service plan not to be covered, Services not specified as being covered in the patient's contract, charges that occur because of missing referrals, deductibles, copays, coinsurance, or because the patient is considered out of network. I understand and agree that it is my responsibility and obligation to obtain a referral if required, and to follow up with my Primary Care Physician Referral Department to be sure my referral has been sent in a timely manner.

Signature _____ Date _____

NOTICE OF HEALTH PRIVACY PRACTICES

I acknowledge that I have been offered and understand Beverly Podiatry's NOTICE OF PRIVACY PRACTICES. This notice describes how we use/disclose your healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. I understand that this Notice of Privacy Practices is available should I wish to take one home with me.

Signature _____ Date _____

MEDICATION HISTORY AUTHORIZATION

By signing below, I authorize Beverly Podiatry to have access to my Medication History.

Signature _____ Date _____

**if minor, please have parent/guardian sign.*

Patient: _____ **MEDICAL INFORMATION**

What is your present foot problem? _____

_____

If Applicable

When did it begin? _____

Locate the area of problem _____

Describe any pain (0 = none 10 = severe) _____

What caused the problem or makes it worse? _____

Was it caused by an injury? _____

Does anything else affect the problem? ❒ yes ❒ no _____

Are there associated symptoms? _____

Post Medical History and System Review

	Yes	No
1. Are you in good health?	❒	❒
2. Have you been under the care of a physician during the past 6 months?	❒	❒
For what condition? _____		
3. Have you experienced ill effects from Novocaine, Penicillin or other drugs?	❒	❒
Please list _____		
4. Do you have any allergies?	❒	❒
Please list _____		
5. Are you pregnant or do you plan to be in the near future?	❒	❒
6. Have you had any serious illnesses or operations?	❒	❒
Please list _____		
7. Have you had any injuries or operations on your feet or legs?	❒	❒

8. Do you smoke? Yes ❒ No ❒ Consume alcohol? Yes ❒ No ❒

9. Is there a family history of diabetes? Yes ❒ No ❒ Arthritis? Yes ❒ No ❒

Family History

Do you have a family history of:

(Mother): ❒ Diabetes ❒ Cancer ❒ Heart Disease ❒ High Blood Pressure ❒ Stroke
❒ Coronary Artery Disease ❒ Thyroid Disease ❒ Rheumatoid Arthritis ❒ Other _____

(Father): ❒ Diabetes ❒ Cancer ❒ Heart Disease ❒ High Blood Pressure ❒ Stroke
❒ Coronary Artery Disease ❒ Thyroid Disease ❒ Rheumatoid Arthritis ❒ Other _____

What is your height and weight ?_____

Please check off if you had any problems with or are presently experiencing any of the following:

❒ High Blood Pressure	❒ Asthma	❒ Blood in Stool	❒ Arthritis
❒ Diabetes	❒ Bronchitis	❒ Ulcers	❒ Low Back Problems
❒ Cancer	❒ Pneumonia	❒ Change in Bowel Habit	❒ Skin Diseases
❒ Heart Disease	❒ Persistent Cough	❒ Unexplained Weight Gain/Loss	❒ Blood Disorders
❒ Chest Pain/Chest Tightness	❒ T.B.	❒ Gall Bladder Disease	❒ Anxiety
❒ Shortness of Breath	❒ Hay Fever	❒ Colitis	❒ Depression
❒ Swollen Ankles	❒ Abdominal Discomfort	❒ Hepatitis or Jaundice	❒ Anemia
❒ Palpitations	❒ Indigestion	❒ Thyroid Disease	❒ Alcohol Abuse
❒ Light-headedness	❒ Nausea	❒ Headache	❒ Drug Abuse
❒ Frequent Urination	❒ Vomiting	❒ Kidney Disease	❒ Gout
❒ Rheumatic Fever	❒ Constipation	❒ Kidney Stones	❒ Other _____
	❒ Diarrhea		

10. What medications are you presently taking? _____

_____

11. Is there any other information about your health which should be known?_____