New Patient Information

Full Name: ______________________________ DOB: __________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*
____
City *State* *ZIP Code*

Cell: __________ Home: __________ Email: __________

Sex: ☐ M ☐ F Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Ethnicity: ☐ Hispanic ☐ Not Hispanic

Emergency Contact: ______________________________ Telephone: __________

Occupation/Employer: ______________________________

Pharmacy: ______________________________ Telephone: __________

Address: ______________________________

Primary Care: ______________________________ Telephone: __________

Address: ______________________________ Last Seen: __________

Referring Provider: ______________________________ Telephone: __________

Insurance Information

☐ **No Insurance**

Primary Insurance: __________ __________

Subscriber: __________ Relationship: __________ DOB: __________

Policy ID: __________ Group ID: __________

Secondary Insurance: __________ __________

Subscriber: __________ Relationship: __________ DOB: __________

Policy ID: __________ Group ID: __________

What Is Bringing You In Today?

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Family Member ☐ Friend ☐ Other ________

Reason for Visit Today: ______________________________

Side: ☐ Right ☐ Left Result of accident or work injury? ☐ Yes ☐ No

How long has this bothered you? ________ ☐ Days ☐ Weeks ☐ Months ☐ Years
On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10
Pain can be described as ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Other ______________

Medical History

- ☐ None
- ☐ Diabetes
  - o Insulin
  - o Oral medications
  - o HbA1c: ________%
  - o Last PCP/Endocrine visit: ___________
- ☐ Rheumatoid disease (specify) ______________
- ☐ Arthritis (specify) ______________________
- ☐ Gout
- ☐ Peripheral vascular disease/circulation problems
- ☐ Blood disorders
- ☐ Kidney disease
- ☐ Hepatitis/Liver disease
- ☐ Neuropathy
- ☐ Blood clot
- ☐ Pulmonary embolism
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Cancer (specify) ______________________
- ☐ Asthma
- ☐ COPD
- ☐ Allergies
- ☐ CVA/Stroke
- ☐ Anxiety disorder
- ☐ Mental illness
- ☐ Alcoholism
- ☐ Sleep apnea
- ☐ Stomach/bowel
- ☐ HIV
- ☐ Skin disorders (specify) ________________
- ☐ Other: ____________________________

Surgical History

- ☐ None
- ☐ **Foot/ankle** surgery (specify)__________________
  ____
- ☐ Amputation (specify)______________________
- ☐ Cardiac bypass
- ☐ Angiogram/plasty/stenting
- ☐ Joint replacement (specify) ______________
- ☐ Artificial heart valve (specify) ______________
- ☐ Other: ______________________________
  ____

Family History

- ☐ N/A ________________________
- ☐ Diabetes ________________________
- ☐ Autoimmune/rheum ________________________
- ☐ Cancer ________________________
- ☐ Blood Clot ________________________
- ☐ Circulation problem ________________________
- ☐ Gout ________________________
- ☐ Heart disease ________________________
- ☐ Hypertension ________________________
- ☐ Stroke ________________________
- ☐ Bleeding disorders ________________________
- ☐ Depression ________________________
- ☐ Neurologic ________________________
- ☐ Other (specify) ________________________

Social History

Smoking status: ☐ Never ☐ Former, quit year _________, _______/day x ____ years ☐ Current, _______/day x ____ years

Drinking status: ☐ Yes, daily (5-7 days/week) ☐ Yes, socially/occasionally ☐ No/rarely

Substance abuse: ☐ Never ☐ Former (specify) ______________________ ☐ Currently (specify) ______________________

Do you exercise? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise:____________________________

Advanced Directives: ? ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

Medications

☐ None

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Name/Dose ______________________________

Allergies

☐ No known drug allergies

Name ______________________________ Reaction ______________

Name ______________________________ Reaction ______________

Name ______________________________ Reaction ______________

Name ______________________________ Reaction ______________

Signature: ______________________________ Date:______________

Patient Financial Liability Statement

Patient Name: ____________________________ Date ____________________

I understand that I am personally and financially responsible for charges incurred for services rendered at Bear Foot And Ankle in the event that any of the following issues apply:

- My health benefit plan requires prior authorization or referral by a primary care physician before receiving services at Bear Foot And Ankle
- My health plan determines that the services I received at Bear Foot and Ankle are, in their opinion, not deemed medically necessary.
- My health coverage has lapsed or expired at the time of services rendered at Bear Foot and Ankle
- My health plan is not one that Bear Foot and Ankle has elected to participate with.
- I have elected not to use my health insurance plan coverage or have no coverage.
- I also understand that I am responsible for all co-pays, co-insurances and deductibles under my health plan.

I understand that I am responsible for any balances not paid by my insurance company and certify that all the information given by me is accurate for collection. I also authorize payment be made to the provider and any requested medical records required for payment of benefits be given to insurance company upon request.

In the event of insurance denials, I hereby authorize Bear Foot and ankle to act on my behalf to arbitrate with the insurance companies to resolve the issue.

Any balances remaining unpaid by insurance for deductibles, co-payments, and co-insurances are the financial responsibility of that of the patient.

Signature ________________________ Date ________________________

Patient Consent for Use and Disclosure of Protected Health Information

I hereby consent to photographs to be taken for the purpose of medical record keeping and to be incorporated into the medical record. Photos will not be used for advertising without additional consent.

Signature ________________________ Date ________________________

Who can we discuss your care with?

Name: ____________________ Relationship: ________________ Telephone: ________________

Name: ____________________ Relationship: ________________ Telephone: ________________

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason, they do not pay my bill, I am responsible.

☐ I have received the Confidentiality Agreement (HIPAA) and agree to comply. ☐ I have read the financial policy and agree to comply.

Signature: ________________________________ Date: ________________