ADVANCED FOOT
ANKLE & WOUND CARE

WELCOME TO OUR PRACTICE!

NEW PATIENT PAPERWORK

MACOMB FOOT
ANKLE & WOUND CARE

NAME: _____
LAST FIRST

ADDRESS: _____
STREET # STREET

_____
CITY STATE ZIP CODE

BIRTHDATE: _____ SOCIAL SECURITY# _____ GENDER: _____

MARITAL STATUS: _____ NAME OF SPOUSE: _____
IF APPLICABLE

HOME PHONE #: _____ CELL #: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US: *PLEASE SELECT ONE*

ALEXA/SIRI: ☐
ONLINE SEARCH ☐
YELLOW PAGES ☐
CARD IN MAIL ☐

REFERRAL FROM PHYSICIAN: _____
PHYSICIANS NAME

OTHER PATIENT/FRIEND/FAMILY: _____
NAME

PRIMARY CARE PHYSICIAN (PCP): _____
SOME INSURANCE COMPANIES REQUIRE THIS INFORMATION TO BE ON FILE FOR REIMBURSEMENT

PCP #: _____ LAST VISIT WITH PCP: _____

WOULD YOU LIKE APPOINTMENT REMINDERS: YES ☐ NO ☐

IF "YES" HOW WOULD YOU LIKE TO BE REMINDED:

TEXT MESSAGE: ☐ CELL PHONE: ☐
HOME PHONE: ☐ EMAIL: ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES WE WILL NEED A COPY OF YOUR INSURANCE CARD

SUBSCRIBERS NAME: _____ SUBSRIBERS DOB: _____

INSURANCE COMPANY NAME: _____
CONTRACT #: _____ GROUP #: _____

IF YOU HAVE SECONDARY INSURANCE PLEASE COMPLETE THE FOLLOWING:
CONTRACT #: _____ GROUP #: _____

DOES YOUR INSURANCE POLICY REQUIRE REFERRAL? YES ☐ NO ☐
IF "YES" PLEASE PROVIDE THAT REFERRAL TO OUR FRONT DESK FOR SUBMISSION TO YOU FILE

PLEASE NOTE: IF YOU DID NOT BRING INSURANCE CARDS WITH YOU, ALL CHARGES WILL BE YOUR RESPONSIBILITY AND PAYABLE AT THE TIME OF SERVICE. OBTAINING REQUIRED REFERRAL FORMS IS THE PATIENTS RESPONSIBILITY.

MEDICAL INFORMATION

CURRENT WEIGHT _____ CURRENT HEIGHT: _____ SHOE SIZE: _____

WHAT IS THE REASON FOR YOUR VISIT (*COMPLAINT*):

- ☐ ANKLE PAIN
- ☐ BURNING/TINGLING
- ☐ CORNS/CALOUSES
- ☐ DIABETIC FOOT EXAMINE
- ☐ DIABETIC SHOES
- ☐ FOOT PAIN
- ☐ HEEL PAIN
- ☐ INGROWN TOE NAIL
- ☐ INGROWN TOE NAIL
- ☐ MYCOTIC NAILS
- ☐ PAIN WHILE WALKING
- ☐ ROUTINE FOOT CARE
- ☐ SWELLING
- ☐ TOE
- ☐ WOUND OR ULCER CARE
- ☐ OTHER: _____

HAVE YOU BEEN TREATED FOR THIS BEFORE? IF YES, BY WHOM: _____

HAVE YOU HAD PREVIOUS CONDITIONS OF YOUR FOOT/ANKLE: _____

REVIEW OF SYMPTOMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL

- ☐ FATIGUE
- ☐ FEVER
- ☐ GOOD HEALTH LATELY
- ☐ HEADACHES
- ☐ RECENT WEIGHT CHANGE

EYES

- ☐ BLURRED OR DOUBLE VISION
- ☐ EYE DISEASE OR INJURY
- ☐ WEAR GLASSES/CONTACTS

EAR/NOSE/MOUTH/THROAT

- ☐ EARARCHES OR DRAINAGE
- ☐ HEARING LOSS OR RINGING
- ☐ MOUTH SORES
- ☐ NOSE BLEEDING
- ☐ SINUS PROBLEMS
- ☐ SWOLLEN GLANDS IN NECK

CARDIOVASCULAR

- ☐ CHEST OR ANGINA
- ☐ HEART PROBLEMS
- ☐ PALPITATIONS
- ☐ SHORTNESS OF BREATH WITH EXERTION
- ☐ SWELING OF FEET, ANKLES OR HANDS

RESPIRATORY

- ☐ CHRONIC OR FREQUENT COUGHS
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ SPITTING UP BLOOD

GASTROINTESTINAL

- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ LOSS OF APPETITE
- ☐ NAUSEA OR VOMITING
- ☐ RECTAL BLEEDING OR BLOOD IN STOOL

GENITOURINARY

- ☐ BLOOD IN URINE
- ☐ BURNING OR PAINFUL URINATION
- ☐ FREQUENT URINATION

MUSCULOSKELETAL

- ☐ BACK PAIN
- ☐ COLD EXTREMITIES
- ☐ DIFFICULTY WALKING
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS OF SWELLING
- ☐ MUSCLE PAIN OR CRAMPS
- ☐ WEAKNESS OF MUSCLES OR JOINTS

INTEGUMENTARY (SKIN)

- ☐ CHANGE IN HAIR OR NAILS
- ☐ CHANGE IN SKIN COLOR
- ☐ RASH OR ITCHING
- ☐ VARICOSE VEINS

FAMILY HISTORY

IS YOUR MOTHER LIVING? YES ☐ NO ☐ CAUSE OF DEATH: _____

IS YOUR FATHER LIVING? YES ☐ NO ☐ CAUSE OF DEATH: _____

HAS ANYONE IN YOUR FAMLY BEEN DIAGNOSED WITH THE FOLLOWING?

PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THE FAMILY MEMBERS RELATION TO YOU IN THE SPACE PROVIDED.

☐ HEART DISEASE	_____	☐ BLEEDING DISORDER	_____
☐ CANCER	_____	☐ STROKE	_____
☐ HYPERTENSION	_____	☐ DIABETES	_____
☐ ARTHRITIS	_____	☐ HAMMERTOES/BUNIONS	_____
☐ SKIN DISEASE	_____	☐ FLATFEET	_____
☐ FOOT PROBLEMS	_____	☐ CIRCULATION PROBLEMS	_____

SOCIAL HISTORY

DO YOU LIVE ALONE? YES ☐ NO ☐

DO YOU HAVE CHILDREN? YES ☐ NO ☐ HOW MANY? _____

DO YOU EXERCISE? YES ☐ NO ☐ HOW OFTEN? _____

DO YOU CURRENTLY SMOKE? YES ☐ NO ☐ HOW MUCH? _____

HAVE YOU EVER SMOKED? YES ☐ NO ☐ HOW LONG AGO DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ HOW MUCH? ___DAILY ___WEEKLY___MONTHLY

WHERE DO YOU WORK? _____

EMPLOYER ADDRESS: _____

STREET # STREET

_____

CITY STATE ZIP CODE

WHAT TYPE OF PHYSICAL ACTIVITY DOES YOUR JOB REQUIRE?

☐ MOSTLY SITTING
☐ MOSTLY STANDING
☐ STANDING AND WALKING
☐ MOSTLY STANDING
☐ RETIRED

DO YOU HAVE ANY KNOW ALLERGIES? IF YES, PLEASE LIST: _____

_____

PLEASE LIST THE MEDICATIONS AND VITAMIN YOU ARE CURRENTLY TAKING AND THE DOSAGE:

_____

_____

_____

_____

WHAT IS YOUR PREFERRED PHARMACY? NAME AND LOCATION PLEASE: _____

_____

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ANKLE & WOUND CARE

MACOMB FOOT
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2023

IMPORTANT INFORMATION ABOUT YOUR VISIT

Thank you for visiting our office. We are so grateful for your patronage and are committed to providing the highest level of podiatric and customer care.

Please review the following information regarding our mutual relationship with the insurance providers we participate with. We will do our best to answer any questions you may have, but your insurance company is your best resource regarding the details of your individual policy.

Advanced Foot, Ankle & Wound Care & Macomb Foot, Ankle & Wound Care

Our physicians and office are contracted with many insurance companies. Our obligation to each of the insurance companies we participate with is to bill for the services rendered on our patient's behalf. Per our contracts we are obligated to accept the payment they render (regardless of what we billed) in addition to billing for, and collecting, any deductibles and/or co-payments from our patients as directed by their individual policy with their insurance company.

We take this responsibility very seriously as deviating from it could result in sanctions or dismissal from our contracts. ☐ Initial Here

Patient Responsibility:

As a patient you are financially responsible for all charges associated with services/treatment provided at your visit. We accept payment from your insurance company (which may include deductible, co-payment, or out-of-pocket costs paid directly by you as dictated by your contract with your insurance company) or by personal payment if you do not have currently have insurance coverage or we do not accept your insurance. This includes but is not limited to office visits, treatments, durable medical equipment, procedures, x-rays, injections, routine foot care and surgeries. ☐ Initial Here

If your insurance company requires a referral, it is your responsibility to obtain it. Without the referral, your insurance company will not pay for the services, and you will be financially responsible. ☐ Initial Here

Most insurance policies have some form of cost sharing via deductible or co-payment. It is your responsibility to understand your policy and your status with any deductible/co-pay/coinsurance as it will be due at the time of your visit. ☐ Initial Here

If you have received any Durable Medical Equipment (shoes, orthotics, braces, inserts, airheels, etc.) it is your responsibility to let the staff know prior to accepting any additional equipment/shoes/orthotics, etc. Most insurance companies have a maximum number of units allowed during a certain time frame and if you have received equipment from another provider

within that allowed time frame the equipment you receive at our office may not be covered and you will be financially responsible. Initial Here

If your insurance has changed or has been terminated at the time of your visit, you are financially responsible for the balance in full. Please be sure to inform the office of any changes to your primary or secondary insurance coverage at the time of your visit. Initial Here

Cash Balances must be **paid in full** to make an appointment. If you have an outstanding balance your prompt payment is appreciated so as not to delay scheduling. As always, co-pays are due at the time of your visit. We accept cash, checks and credit card payments for your convenience.

AUTHORIZATION/CONSENT FOR TREATMENT AND PRIVACY POLICY AND INFORMATION:

I hearby consent to the treatment provided by Advanced Foot, Ankle & Wound Care/Macomb Foot, Ankle & Wound Care and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. Initial Here

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting healthcare. I authorize Advanced Foot, Ankle & Wound Care/Macomb Foot, Ankle & Wound Care to release any information required in the process of applications for financial coverage for services rendered. This authorization provides that Advanced Foot, Ankle & Wound Care/Macomb Foot, Ankle & Wound Care may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or their designated agent. Initial Here

I authorize payment to made directly to Advanced Foot, Ankle & Wound Care /Macomb Foot, Ankle & Wound Care for insurance benefits payable to me. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection's agency, I will be responsible for the costs of collection including any potential attorney fees. Initial Here

I understand the importance of keeping my scheduled appointments and that a $35 fee will be charged to my account for any missed appointments not cancelled 24 hours to my scheduled appointment time. Initial Here

I authorize Advanced Foot, Ankle & Wound Care /Macomb Foot, Ankle & Wound Care to obtain my prescription information from the last two years electronically through MEDHX and have that prescription information added to my health record. Initial Here

I acknowledge that I have been offered the Providers "Notice of Privacy Policies". My rights including the right to see and copy my record, limit disclosure of my health information and to request an amendment to my record is explained in the policy. I understand that I may revoke, in writing, mu consent for release of my healthcare information, except to the extent in which my doctor has already made disclosures with my prior consent.

By signing this document, I certify that I understand and accept my responsibilities as outlined above.

Patient Signature

Signed By: Date: