Podiatry of Arlington Heights New Patient Forms

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SECTION 1 - PATIENT INFORMATION:

DEMOGRAPHICS

First Name:	Last Name:	Date of Birth:	
Street Address:	City:	State	Zip Code:
Home Phone Number:	Cell Phone Number:	Email:	
Pharmacy Name:	Pharmacy Location/Phone Number:		

EMERGENCY CONTACT

Emergency Contact Person:	Emergency Contact Number:

PRIMARY CARE & REFERRAL INFORMATION

How did you hear about our office?	
Primary Care Physician (PCP):	PCP Phone Number:
Date of Last Visit with PCP:	Referred By:

INSURANCE INFORMATION:

A copy of your insurance card will be made at your appointment. If you do not have your insurance card with you the day of your appointment then you will be charged as a cash pay patient upfront the day of the appointment.

SECTION 2 - History of Present Illness:

What is the reason for your visit today?	Which foot has an issue?
What treatments have you tried so far?	How long has this bothered you?

SECTION 3 - MEDICAL HISTORY

SURGICAL HISTORY *(Check all that apply or check "none" box)*

● None ● AAA Repair ● Carotid Surgery ● Fracture Repair ● Joint Replacement	● Amputation ● Cataract ● Heart Valve ● Pacemaker	● Angioplasty ● C-Section ● Hernia Repair ● Prostate Surgery	● Appendectomy ● Cholecystectomy ● Hysterectomy ● Shoulder Surgery	● CABG ● Colectomy ● Knee Surgery ● Thyroidectomy

- **Other Procedures or Surgeries: _____**

MEDICAL HISTORY *(Check all that apply or check "none" box)*

● None ● Alcoholism ● Asthma ● Breast Cancer ● Cancer ● Diabetes Type___ ● Gout ● Hypertension ● Mental Illness ● Skin Disorder ● Thyroid Disease	● Allergies ● BPH (prostate) ● Breathing Disorder ● Cholesterol High ● Epilepsy ● HIV ● Kidney Disease ● Migraines ● Sleep Apnea ● Ulcer GI	● Anemia ● Back Problems ● Coronary Artery Dx ● Circulation Problem ● Fibromyalgia ● Heart Disease ● Liver Disease ● Musculoskeletal Dx ● Stomach Disorder	● Anxiety ● Blood Clot ● CHF ● Dementia ● GERD ● Heart Murmur ● Lymphedema ● Neuropathy ● Stroke	● Arthritis ● Blood Dx ● COPD ● Depression ● Glaucoma ● Hepatitis ● Heart Attack ● Pneumonia ● TB

- **Other medical issues not listed above_____**

Are you pregnant? YES / NO **Are you Nursing? YES / NO**

FAMILY HISTORY *(please indicate which immediate relative, i.e - mom, dad, brother or sister)*

● Alzheimer's Dx _____ ● Arthritis _____ ● Bleeding Disorder _____ ● Blood Clot _____ ● Cancer_____ ● Cataracts _____ ● Circulation Problems _____ ● Other _____	● Depression _____ ● Diabetes _____ ● Emphysema_____ ● Heart Disease_____ ● Neurological _____ ● High Blood Pressure _____ ● Strokes _____

SOCIAL HISTORY

Do you Smoke? YES / NO	If Yes, How many packs/day? _____	How long have you smoked? _____
Do you drink alcohol? YES / NO	If Yes, How many drinks/week?_____	Do you use illicit substances? YES / NO
What is Your Occupation? _____	Do you sit or stand at work? _____	What type of exercise do you do? _____

REVIEW OF SYSTEMS (*please check the box if you have any of these symptoms or check "NONE")*

Constitutional	Head	Eyes	Respiratory	Cardiovascular	Gastrointestinal
● NONE ● Fever ● Chills ● Weight Loss ● Decline in health ● Weakness ● Weight Gain	● NONE ● Dizziness ● Fainting ● Head Injury ● Headaches	● NONE ● Blurred Vision ● Cataracts ● Double Vision ● Glasses ● Glaucoma ● Vision Loss	● NONE ● Asthma ● Cough ● Wheezing ● Shortness of Breath ● TB	● NONE ● Chest Pain ● Palpitations ● Hair loss legs ● Cold Extremities	● NONE ● Nausea ● Vomiting ● Constipation ● Diarrhea ● Abdominal Pain
Musculoskeletal	**Psychiatric**	**Skin**	**Neurological**	**Endocrine**	**Genitourinary**
● NONE ● Joint Pain ● Joint Stiffness ● Gout ● Arthritis ● Weakness ● Cramping	● NONE ● Depression ● Anxiety ● Memory Loss ● Mood Changes	● NONE ● Dryness ● Rash ● Wounds ● Itching ● Nail Abnormal	● NONE ● Fainting ● Dizziness ● Numbness ● Tingling ● Tremors	● NONE ● Goiter ● Excess Thirst ● Cold/Heat Intolerance ● Fatigue	● NONE ● Excessive Urination ● Stones ● Incontinence ● Retention

ALLERGIES

- No known drug allergies
- Drug Allergy: _____ Reaction: _____
- Drug Allergy: _____ Reaction: _____
- Drug Allergy: _____ Reaction: _____
- Drug Allergy: _____ Reaction: _____
- Drug Allergy: _____ Reaction: _____

MEDICATIONS

- NONE

MEDICATION	DOSAGE	FREQUENCY

VITAL SIGNS

Current Height: _____ Current Weight _____

SECTION 4 - PRACTICE POLICY AGREEMENTS

POLICY 1 - *Medical History / HIPAA / Release of Information Policy*

_____ Patient Initials - The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I'm responsible for notifying the physician of any and all updates to the information listed above. I authorize the release of any medical information necessary to process this claim. I acknowledge that I received my HIPAA Privacy Practices Notice. I authorize the Physician's office to retrieve my medical history.

POLICY 2 - *Insurance Processing Policy*

_____ Patient Initials - I certify that the insurance coverage I provided to the office is valid and I assign directly to this medical practice all Insurance benefits. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.

POLICY 3 - *24 Hour Appointment Cancellation Policy*

_____ Patient Initials - I acknowledge the 24-hour cancellation policy for this practice that states if I miss or cancel my appointment with less than 24 hours notice that I will be charged $50.

POLICY 4 - *Credit Card Policy*

For all patients that always pay their responsible balances in a timely manner, we greatly appreciate your conscientiousness and apologize for any inconvenience this may cause. It has become mandatory for our practice to require a credit card to be kept on file for any balances that may accrue on your patient account.

This policy applies to all patients, excluding those covered by a MEDICARE policy. You will receive 3 paper statements by mail. The first statement at 30 days post visit, another at 60 days and the final statement at 90 days after your visit. If the balance reaches an aged date exceeding 90 days with no payment, the credit card on file will be charged for the balance and you will receive a mailed receipt for your records. By signing below, you authorize our office to charge the credit card on file for any outstanding patient balance exceeding an aged-date of 90 days or more.

Patient Signature: _____ Date: _____

Credit Card Number: _____

Name on Card: _____

Expiration Date: _____CVV: _____