

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:
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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?
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What treatments have you tried so far?	How long has this bothered you?
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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
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• 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
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• 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 _____
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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? _____

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

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

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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 and Deductible Deposit 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.

_____ Patient Initials – I acknowledge that if I have not met my insurance deductible, I will be required to pay a \$100 deposit at the time of service. This deposit will be applied towards any outstanding balance after the insurance claim has been processed. If the balance exceeds \$100, I will be billed for the remaining amount. If the balance is less than \$100, any overpayment will be refunded once all insurance claims have been processed.

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

Effective 1/1/2021, Podiatry of Arlington Heights requires a credit card to be on file for all patients with commercial insurance.

This policy applies to all patients, excluding those covered by a **MEDICARE** policy.

Patients will receive **3 paper statements by mail**. The first at 30 days after your appointment, the second at 60 days and the final statement at 90 days after your visit. You will also receive a text message statements with a payment link. 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 Podiatry of Arlington Heights to scan your credit card on file in your chart for any outstanding patient balance exceeding an aged date of 90 days or more.

Patient Signature: _____ Date: _____

Last 4 digits of Credit Card: _____