Clinch Valley Family Podiatry PLLC
PATIENT INFORMATION

Date of Birth: ____/____/_____

Patient Name: _____ Soc. Sec. #: _____

Physical Address: _____
(Street – NO PO BOXES) (City) (State, Zip Code)

Billing Address: _____

Home Phone: _____ Mobile Phone: _____

Other Phone: _____ Work Phone: _____

Email Address: _____

Marital Status**:** (Single) (Married) (Divorced) (Widowed) Gender**:** (Male) (Female)
Circle One Please) (Circle One Please)

Primary Language**:** (English) (Spanish) (Other) If other, please explain: _____
(Circle One Please)

Race**:** (White) (Asian) (Black/African Amer.) (Native Hawaiian/Islander)

(Hispanic or Latino) (Amer. Indian/Alaskan Native) (Prefer Not to Answer)
(Please Circle Any/All That Apply)

Pharmacy: _____
(Name of Pharmacy) (City) (State) (Zip code)

Name of Insurance Company: _____

Insurance Subscriber (Name on Card): _____

Subscriber Date of Birth: _____ Subscriber Soc. Sec # _____

Person Responsible for Account: _____Date of Birth: _____ Soc.Sec. #: _____

Employer: _____ Occupation: _____

Responsible Party's Address: _____
(Street) (City) (State, Zip Code)

Responsible Party's Relation to Patient: _____

Patient's Primary Care Physician: _____

Patient's Referring Physician: _____

Medical History and Patient Information

Patient's Name _____

MEDICAL INFORMATION GENERAL

Family Physician_____ Telephone _____

Have you seen another doctor for your foot problems? ☐Yes ☐No
Was the doctor a podiatrist? ☐Yes ☐No

Name and telephone number of previous doctor(s) who treated your foot problem(s):

_____
_____
_____

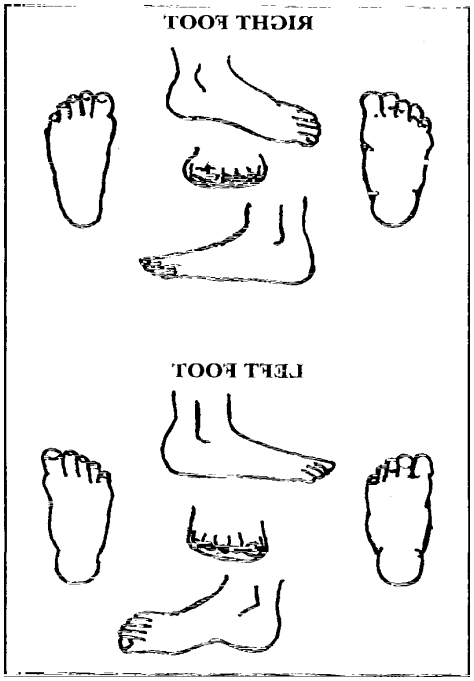
What is your foot problem? _____

How long have you been bothered by this problem? What have you done for your foot problem(s)?

_____

_____

On the diagram below, please mark the place(s) where you are experiencing pain in your feet:



Medical History and Patient Information
Patient's Name _____

PLEASE CHECK ANY OF THE SYMPTOMS BELOW THAT YOU HAVE REGULARY

CONSTITUTIONAL
☐Cancer _____
☐Chills
☐Fever
☐Fibromyalgia
☐Generalized pain
☐Headache
☐HIV
☐Liver disease
☐Sickle Cell Disease
☐STD
☐Other _____

CARDIOVASCULAR
☐Atrial Fibrillation
☐Blood clots
☐CHF
☐Heart Attack
☐Heart Disease
☐Heart Murmur
☐Heart Palpitations
☐High Blood pressure
☐High Cholesterol
☐Rheumatic Fever
☐Other _____

DERMATOLOGIC
☐Changing Moles
☐Dry Skin
☐Hair Problems
☐Itching
☐Nail Problems
☐Psoriasis
☐Other _____

EAR, NOSE, THROAT
☐Cataract
☐Glaucoma
☐Other _____

ENDOCRINE
☐Diabetes
☐Excessive Thirst
☐Temperature Intolerance
☐Thyroid Disease
☐Other _____

GASTROINTESTINAL
☐Abdominal Pain
☐Belching (eructation)
☐Bloating
☐Bloody Stool
☐Chronic Constipation
☐Diarrhea
☐Heartburn/Acid reflux
☐Hemorrhoids
☐Lactose Intolerant
☐Mucous in Stool
☐Nausea/vomiting
☐Pain when Defecating
☐Other _____

GENITOURINARY
☐Blood in Urine
☐Burning during Urination
☐Changes in Urinary
☐Kidney Disease
☐Kidney Stones
☐Urinary Tract Infections
☐Other _____

IMMUNOLOGIC
☐Environmental Allergies
☐Immune Deficiency
☐Persistent Infections
☐Strong Allergic reaction
☐Other _____

MUSCLOSKETAL
☐Artificial Joints _____
☐Arthritis
☐Ankle pain
☐Arch pain
☐Back pain
☐Gout
☐Joint pain
☐Joint swelling
☐Joint stiffness
☐Muscle cramps
☐Muscle pain
☐Osteoporosis
☐Unequal Leg Length
☐Other _____

NEUROLOGIC
☐Epilepsy
☐Muscle Weakness
☐Numbness of Toes/Feet
☐Poor Balance
☐Shooting Pain Toes/Feet
☐Tingling/Burning of Feet
☐Other _____

PSYCHIATRIC
☐NO Psychiatric Symptoms
☐Anxiety
☐Depression
☐Sleep Disturbances
☐Other _____

RESPIRATORY
☐Asthma
☐COPD
☐Pulmonary Disease
☐Tuberculosis
☐Other _____

VASCULAR
☐Calf Claudicating
☐Chest Pain
☐Cold, Numb Hands/Feet
☐CVA
☐Deep Vein Thrombosis
☐Edema of Feet or Legs
☐Palpitations
☐Poor Circulation
☐Rest Pain
☐Varicose Veins
☐Other _____

MEDICATIONS (Please list name(s), dosage(s), reason for taking it/them):

_____

_____

_____

_____

_____

_____

Have you taken Prednisone over the past 6 months? ☐ Yes ☐ No

SURGERIES & HOSPITALIZATIONS:

_____

_____

_____

_____

DO YOU HAVE A FAMILY HISTORY OF:

☐ ARTHRITIS
☐ BLEEDING DISORDER
☐ CANCER
☐ CARDIOVASCULAR DISEASE
☐ DIABETES
☐ HYPERTENSION
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ PERIPHERAL VASCULAR DISEASE
☐ PULMONARY DISEASE

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?	**WHAT IS YOUR REACTION?**
☐ ASPIRIN	_____
☐ CODEINE	_____
☐ CORTISONE	_____
☐ IODINE	_____
☐ LOCAL ANESTHSIA	_____
☐ MERCURIALS	_____
☐ NOVOCAIN	_____
☐ PENICILLINS	_____
☐ SULFA DRUGS	_____
☐ OTHER _____	_____
☐ NO KNOWN DRUG ALLERGIES	

Financial Policy for Clinch Valley Family Podiatry PLLC

- Payment in full is due at time of service unless prior arrangements have been made.
- Office visit co-payments are due at the time of service.
- If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 45 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 45 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.
- HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.
- Please present your insurance card each time you visit to insure that we have proper filing information to submit claims.
- There is a $25.00 charge for all returned checks.
- All unpaid balances are subject to 1.5% interest charge after 90 days.
- Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you miss a scheduled appointment without notifying our office a $25.00 charge will be added to your account.
- If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees, interest charges and/or attorney fees charged by these services.
- I HEREBY AUTHORIZE RELEASE OF INFORMATION AND/OR MEDICAL RECORDS OF MYSELF, TO ANY TREATING PHYSICIAN, OR INSURANCE COMPANY.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with _____ and assign directly to **Clinch Valley Family Podiatry PLLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: _____

Printed Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was offered (accepted/declined) a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so choose so) and understand the Notice.

_____

Name(s) of Persons Authorized By Me to Receive My Medical Information

X_____ _____

Patient Signature (Parent/Guardian) Date

Sam Scott, DPM

Patient Name: _____ Date: _____

BP: _____ Allergies: _____

Temp: _____ HT: _____

Referred by: _____ WT: _____

CC:

_____

_____

_____

_____

_____

Date of last physical exam: _____

Do you smoke? ☐Yes ☐No If yes, # of packs per day: _____

Previously smoked? ☐Yes ☐No Yrs smoked: _____ Pks per day _____Yr stopped: _____

Are you exposed daily to second hand smoke? ☐Yes ☐No

Do you drink? ☐Yes ☐No

If yes, how often? ☐ Less than 1/week ☐ 1-2/week ☐ 1-2/daily ☐ More than 2 daily

Do you or have you ever-used drugs? ☐Yes ☐No

Do you drink caffeine? ☐Yes ☐No ☐ 1-2/week ☐ 1-2/daily ☐ More than 2 daily

WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, # of months pregnant: _____

1. Are you under active care for Diabetes and or circulation problems? ☐ Yes ☐ No

If you answered yes to questions 1 above, please answer questions 2-5 below:

2. Doctor's name, city and state: _____

3. Date last seen by the above doctor: _____

4. Type of Diabetic: ☐ Insulin Dependent ☐ Diet Controlled ☐ Medication Controlled (pill)

5. Number of years being diabetic: _____ Average blood sugar range: _____