Sarasota Foot Care Center, PA

Please print clearly

Account Number _____

Name _____
(Last) (First) (Middle)

Local Address _____

_____
City State Zip

Northern Address _____

_____
City State Zip

Local Phone _____ **Cell Phone** _____ **Northern Phone** _____

Date of Birth _____ **Age** _____ **Gender:** ☐ **Female** ☐ **Male** **Social Security #** _____

Email Address _____

Race:	**Ethnicity:**	**Smoking:**	**Marital Status:**	**Language:**	**Employment:**	**Student:**
☐ Caucasian	☐ nonHispan	☐ Daily	☐ S	☐ English	☐ Full time	☐ Full time
☐ Black	☐ Hispanic	☐ Some days	☐ M	☐ Spanish	☐ Part time	☐ Part time
☐ Asian		☐ Former	☐ D	☐ Other		
		☐ Never	☐ W			

Occupation _____ **Employer** _____ **Phone** _____

Work address _____

Next of Kin _____ **Phone #** _____

Responsible party (for minor) _____ **Relationship** _____
(Last) (First)

Their employer _____ **Occupation** _____ **Phone** _____

Primary Insurance _____ **Secondary Insurance** _____

Name of policy holder _____ **DOB** _____ **SS#** _____

Is Insurance through employer? ____ Yes ____ No **Yours or Spouse?** _____

Pharmacy _____ **Location** _____ **Phone #** _____

IF WE CANNOT VERIFY YOUR INSURANCE BENEFITS BEFORE YOU ARE SEEN, YOU WILL BE ASKED FOR PAYMENT IN FULL

IF THIS VISIT IS RELATED TO A WORK INJURY, AUTO ACCIDENT, OR INVOLVES ANY TYPE OF LIGITATION, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

I hereby authorize the release of any medical information necessary for processing claims and payment of medical benefits to myself or the party who accepts assignment (lifetime signature). **I understand that, as the patient receiving medical treatment, I am responsible for payment regardless of insurance coverage or litigation.**

Patient Signature _____ **Date** _____
(Responsible party)

(over)

Account Number: _____ **SARASOTA FOOT CARE CENTER, PA**

Name_____ Birthdate_____ Date_____

Height_____ Weight_____ Race _____ Language_____ Shoe size_____

Reason for visit_____

_____

_____

Whom may we thank for referring you to our office?_____ Date of onset_____

Medical Doctor _____ Date last seen_____ Former Podiatrist_____

Medical History (check only those items that apply)

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Blood disease
- ❑ Cancer
- ❑ Charcot joint
- ❑ CVA (stroke)
- ❑ Depression
- ❑ Diabetes type I
- ❑ Diabetes type II diet/oral/insulin ___yr
- ❑ Eye pathology
- ❑ Gastric reflux
- ❑ GI Ulcers
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Kidney disease
- ❑ Leg cramps
- ❑ Leg numbness
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Peripheral vascular dis
- ❑ Peripheral neuropathy
- ❑ Varicose veins
- ❑ Osteoporosis

Other Medical problems (please list)_____

_____

Surgical History (check only those items that apply)

- ❑ Angioplasty
- ❑ Appendectomy
- ❑ Arterial by-pass
- ❑ Back surgery
- ❑ Breast biopsy
- ❑ Carotid artery sx
- ❑ Cataract
- ❑ Colonoscopy
- ❑ C-section
- ❑ D and C
- ❑ Endoscopy
- ❑ Foot surgery
- ❑ Gall bladder sx
- ❑ Heart by-pass
- ❑ Heart catheter
- ❑ Hernia repair
- ❑ Hip replacement
- ❑ Hysterectomy
- ❑ Kidney removal
- ❑ Kidney stone sx
- ❑ Knee replacement
- ❑ Mastectomy
- ❑ Neck surgery
- ❑ Open heart sx
- ❑ Pacemaker
- ❑ Prostate surgery
- ❑ Tonsillectomy
- ❑ Venous ligation

_____

Other Surgery (please list)_____

_____

Medications (please list and include strength)_____

_____

_____

(Family History: if answering "yes" please circle and include approximate age first diagnosed with the condition)

Family History	(DOB)	(still living)	Diabetes	Heart disease	Cancer	High blood pressure	Bleeding disorder	Arterial disease
Mother	_____	yes no	yes ____	yes ____	yes ____	yes ____	yes ____	yes ____
Father	_____	yes no	yes ____	yes ____	yes ____	yes ____	yes ____	yes ____
Brother	_____	yes no	yes ____	yes ____	yes ____	yes ____	yes ____	yes ____
Sister	_____	yes no	yes ____	yes ____	yes ____	yes ____	yes ____	yes ____

Current Activities and Social History (please check)

- ❑ Alcohol (frequency)_____ Tobacco _____ppd Date quit_____ Caffeine (type)_____
- ❑ PhysicalActivities_____

Allergies (please check)

- ❑ Novocaine
- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Cortisone
- ❑ Adhesive tape
- ❑ Sulfa
- ❑ Other_____

Review of systems (filled out by nurse) **Mental status** alert and oriented / alert but not oriented / confused / lethargic

Head Eyes	dizziness / syncope / headaches / double vision / infection / total blindness
Ears Nose Throat	dysphagia / hoarseness / hearing loss / infection / tinnitus / epistaxis / otalgia / sores
Respiratory	asthma / bronchitis / dyspnea / orthopnea / hemoptesis / emphysema
Cardiovascular	hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack
Gastrointestinal	jaundice / cirrhosis / hepatitis / abnormal stool / GI ulcer / nausea / vomiting
Genitourinary	dysuria / polyuria / hematuria / pyuria / nocturia / renal dialysis / incontinence / urinary infection
Musculoskeletal	joint pain / joint swelling / muscle pain / pain upon standing after sitting / weakness / back pain
Dermatologic	rash / bleeding / bruising / pruritis / hypertrophic nails / ulcer / skin infection / psoriasis
Neurologic	paralysis / stroke / tics / tremors / seizures / tingling / numbness
Allergic/immunologic	allergies / anaphylactic reactions / HIV / immunosuppressed / recurring infections **Tech**_____

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. It is customary to pay for services when rendered unless prior arrangements have been made.

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS: I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims for my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expense. I understand that my authorized representative or I may receive a copy of this authorization request. I also authorize direct payment of benefits to my attending physician.

I have read and/or have been advised to read the entire Financial Policy outlined.

Patient/Guarantor _____ Date_____
(signature)

Patient Name_____
(please print)

Sarasota Foot Care Center, PA
1921 Waldemere Street, Suite 106
Sarasota, FL 34239

Welcome to the office of Sarasota Foot Care Center, PA. Our Front Desk and Billing staff will be happy to assist you in answering any further questions you may have regarding this information.

MANAGED CARE (HMO/PPO/POS/EPO) If we participate with your insurance, you are responsible for paying your co-payment and for obtaining any referrals/authorizations your plan may require at the time of service. We will verify your insurance and benefits. If your deductible has not been met, you will be responsible for payment at the time of service.

MEDICARE PATIENTS -- We accept assignment on all Medicare claims. As a courtesy we will also file your secondary insurance. If we have to file your secondary more than twice or have excessive difficulty collecting the secondary balance, that balance will be billed to you. We do not file tertiary insurance policies.

NO FAULT/WORKERS COMP -- You must provide us with all necessary information to file your claims. Patients must have prior approval before being seen in this office. This is the patient's responsibility to obtain.

MEDICAID: We do not participate with Medicaid. Payment in full is expected at time of service, unless prior arrangements have been made.

SELF-PAY PATIENTS -- If you are uninsured, you are responsible for payment in full at the time of service, unless prior arrangements have been made with our Business Office at (941) 917-6232, Monday-Friday.

We accept cash, checks, MasterCard and Visa.

Sarasota Foot Care Center, P.A.
1921 Waldemere Street #106
Sarasota, FL 34239

Acknowledgement of Receipt of Notice of Privacy Policies

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them, and that I understand the nature of these policies.

_____ _____

Patient Name (Please Print) Date

_____

Signature of Patient (or Patient's Legal Representative)

Important:

Messages containing medical information may be delivered to me via (initial all that may apply):

_____ Work Phone _____ Cell Phone

_____ Voice Mail _____ Home Answering Machine

_____ Designated Family Member:

_____

Name of Designated Family Member

_____ None of the above, Please relay information directly to me.