Sarasota Foot Care Center, PA

Please print clearly

Account Number _____

Name _____
(Last) (First) (Middle)

Billing Address _____

_____
City State Zip

Northern Address _____

_____
City State Zip

Main Phone _____ **Secondary Phone** _____

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

Email Address _____

Race:	**Ethnicity:**	**Smoking:**	**Marital Status:**	**Language:**
☐ Caucasian	☐ nonHispan	☐ Daily	☐ S	☐ English
☐ Black	☐ Hispanic	☐ Some days	☐ M	☐ Spanish
☐ Asian		☐ Former	☐ D	☐ Other____
Other_____		☐ Never	☐ W	_____

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

Emergency Contact _____ **Phone** _____

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

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_____ Shoe size_____ Date of onset of symptoms_____

Reason for visit_____

_____

How did you hear about our office?_____

Medical Doctor _____ Date last seen_____Former Podiatrist_____

Medical History (check only those items that apply)

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Blood disease
- ❑ Cancer, type: _____
- ❑ CVA (stroke)
- ❑ Depression
- ❑ Diabetes Type 1 or 2_____ diet/oral/insulin ___yr
- ❑ Eye pathology
- ❑ Gastric reflux
- ❑ GI Ulcers
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Kidney disease
- ❑ Leg cramps/numbness
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Peripheral neuropathy
- ❑ Peripheral vascular dis
- ❑ Varicose veins
- ❑ Osteoporosis
- ❑ Charcot joint

Other Medical problems (please list)_____

_____

Have you received the flu vaccine this season? Yes No
Have you received the pneumonia vaccine? Yes No

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, type: _____
- ❑ 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)_____

_____

_____

Family History (please circle if positive)	Diabetes	Heart disease	Cancer	High blood pressure
Mother	yes	yes	yes	yes
Father	yes	yes	yes	yes
Siblings	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

Cardiovascular hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack
Gastrointestinal jaundice / cirrhosis / hepatitis / gastric reflux / GI ulcers / nausea / vomiting
Musculoskeletal joint pain / joint swelling / muscle pain / poststatic dyskinesia / 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**_____

Sarasota Foot Care Center, PA

2000 Webber St., Suite 110, Sarasota, FL 34239 (941) 917-6232

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.

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.

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 -- We do not participate in No Fault/ Workers Comp. Payment in full is expected at time of service, unless prior arrangements have been made.

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

We accept cash, checks, MasterCard and Visa.

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)