Nashville Podiatry

Patient Demographic Information:

Name_____ Gender: Male Female SSN# _____-_____-_____

Date of Birth_____/_____/_____ Age_____ E-mail_____

Address _____
Street City Zip

Phone: Home_____ Work_____ Cell_____
Best number to call: (Circle one) Home Work Cell

Contact Preferences:

How would you like our office to contact you? ☐Phone ☐Mail ☐E-mail

If by phone is it ok to leave a message with: ☐Patient only ☐Patient or Spouse ☐Anyone

Emergency Contact:

Name_____Relationship_____

Phone: Home_____Work_____Cell_____

Primary Language: _____

Race: American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Pacific Islander

White

Ethnicity: Hispanic or Latino

Not Hispanic or Latino

How did you hear about us? Friend/Family Internet Insurance Co. Newspaper

Another Doctor Other_____

Responsible Party/ Primary Insurance Carrier (If not self):

Name:_____ Date of birth:_____/_____/_____
SSN#_____-_____-_____ Relationship:_____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Nashville Podiatry of any changes to the above information.

Patient or Guardian Signature:X_____***Date:***_____

History & Medical Information

1. Primary Care Physician:_____
   Date of last visit:_____/_____/_____ Phone Number:_____
2. Explain your foot/ankle problem:_____
3. When did pain/discomfort begin?(date):_____
   Describe pain/discomfort: Burning Numbness Sharp Other:_____
4. What makes the pain/discomfort better?_____
5. What makes the pain/discomfort worse?_____
6. Has the condition been treated? YES NO When?_____
7. How was the condition treated?_____
8. Height_____feet_____inches Weight_____pounds
9. Date of last Flu Shot_____/_____/_____ Date of last pneumonia shot_____/_____/_____
10. **Past Medical History:** ☐ **None**

☐Anemia	☐Epilepsy	☐HIV/Aids	☐Osteoarthritis
☐Arthritis	☐Gout	☐Kidney Disease	☐Prostate Disorder
☐Bleeding Disorders	☐Heart Disease	☐Lung Disorders	☐Rheumatic Fever
☐Cancer	☐Hepatitis	☐Mitral Valve Prolapse	☐Stroke
☐Diabetes Type 1	☐High Blood Pressure	☐Nerve Disorders	☐Thyroid Disorder
☐Diabetes Type 2	☐High Cholesterol	☐Neurological	☐Other:_____

11. List all Medications/herbs/vitamins: ☐ None

_____

_____

Pharmacy name:_____Phone #_____

12. **Allergies:** ☐ None

☐ Anesthesia	☐Narcotic Agents	☐ Sulfa Drugs
☐ Aspirin	☐Penicillin	☐ Other_____
☐ Codeine	☐Radiographic Contrast/Dyes	

13. **Surgical History:** Have you had surgery? YES NO

Describe(surgery/date):_____

_____

14. **Occupation/Job**:_____

15. **Social History:**

☐ Alcohol Use ☐Caffeine ☐ Drug Use ☐ Exercise Habits_____ ☐Nursing ☐Pregnant

****Tobacco Use****(circle one): current daily smoker current social smoker former smoker never smoker smokeless tobacco user former smokeless tobacco user

16. **Family History: (Please indicate if history is on mother or fathers side)**

☐Bleeding Disorders (m or f)	☐Heart Disease (m or f)	☐Mental Illness (m or f)	☐Other_____
☐Cancer (m or f)	☐High Blood Pressure (m or f)	☐Rheumatoid Arthritis (m or f)	
☐Diabetes (m or f)	☐Kidney Disease (m or f)	☐Stroke (m or f)	☐ No family History

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/ Guardian Signature:X_____Date:_____

Review of Systems

1. **Constitutional:**

Chills Fever Sweats Weight Loss(intentional, unintentional) NONE

2. **Head, Eyes, Ears, Nose and Throat:**

Do you wear: Contacts Dentures Eyeglasses NONE

Do you have: Cataracts Difficulty Swallowing Dizziness Double Vision Neck Pain

Nose Bleeds Ringing in Ears Sore Throat NONE

3. **Cardiovascular:**

Cardiovascular Surgery Chest Pain Congestive Heart Failure Heart Attack

Heart Murmur Leg Pain with Exercise Palpitations Swelling in Legs/ Ankles NONE

4. **Hematological/ Lymphatic (blood):**

Anemia Bleeding Abnormalities Lump in Groin or Armpit Lymphoma Swollen Glands NONE

5. **Respiratory:**

Asthma Bronchitis Cough Difficulty Breathing Pneumonia

Previous Pulmonary Disease Shortness of Breath TB (tuberculosis) Exposure or Treatment NONE

6. **Gastrointestinal:**

Acid Reflux Blood in Stool Constipation Decrease in Appetite Diarrhea

Hepatitis Nausea Stomach Ulcers Vomiting NONE

7. **Endocrine:**

Diabetes Kidney Disease Often Thirsty Often Urinating Pancreatitis

Prostate Problems Thyroid Disorder NONE

8. **Musculoskeletal:**

Broken Bones Bursitis Feeling Weak Joint Pain Tendonitis

Weakness of Limbs NONE

9. **Nervous System:**

Aphasia(loss of speech) Ataxia(loss of balance) Confusion Fainting Migraines

Nervous Disorders Neuropathy(loss of sensation) Seizures Speech Difficulties

Strokes NONE

10. **Integumentary:**

Change in Skin Color Cracking of the Skin Eczema Growth on Skin Hair Loss

Keloid Lesions Rash Recurrent Infections

Sensitivity to Sun Skin Ulcers NONE

11. **Psychiatric:**

Anxiety Depression Nervousness Tension NONE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/ Guardian Signature:X_____Date:_____

Assignment of Benefits and Financial Agreement

Nashville Podiatry

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Nashville Podiatry. This authorization is valid until I notify Nashville Podiatry in writing that it is revoked.

I understand that I am responsible for giving Nashville Podiatry the correct insurance information at the time services are rendered. We agree to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my insurance due to my failure to obtain the required referral. I also understand that Nashville Podiatry is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

We at Nashville Podiatry expect that all outstanding balances be paid on your next appointment date before you are seen. In the event that you are sent a statement, payment is expected by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee, for each statement that we mail. If you have made arrangements with our office we will not charge the re-billing fee for statements sent. Your account will be turned over to collections if you do not fulfill the terms of your financial arrangements. If your account is turned over to an outside collection agency you will be liable for all costs of collection and any attorney fees and or court costs incurred by this office.

I understand that there is a $30 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a $25 fee applied to my account.

I understand that I am responsible for all balances that will not be paid by my insurance carrier, including deductibles, copays, co-insurance and out of network penalties AT THE TIME OF SERVICE.

X _____

Signature Date

_____

Patient or Guardian Name (please print) Relationship to patient

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

*IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICE PLEASE ASK THE FRONT RECEPTIONIST

By signing this form, you acknowledge that you can be provided with a copy of our Notice of Privacy Practices.

_____ _____

Signature Date

_____

Pantient or Guardian Name (Please Print)

I give Nashville Podiatry permission to release my medical information to the following person (or people)

_____

_____