Barrett podiatry

Please Print

Name _____ **Date of Birth** _____
Last First Middle

Address _____ **Telephone** _____
Street City Zip Code

Gender: ☐M ☐F Marital Status: ☐Single ☐Married ☐Widow ☐Divorced **Social Security No.** _____

Email Address _____ **Preferred method of contact** ☐email ☐home ☐work ☐cell phone

Employer (patient) _____ Occupation _____

Address ☐Same _____ Telephone _____
Street City Zip

Name of Guarantor (parent) _____ **Date of Birth** _____
Last First Middle

Employer _____ Social Security No. _____

Address ☐Same _____ Telephone _____
Street City Zip Code

Primary Insurance _____ **Secondary Insurance** _____

_____ _____
Name of policy holder Date of birth Name of policy holder Date of birth

Policy# _____ Group# _____ Policy# _____ Group# _____

Emergency Contact _____ **Telephone** _____

Primary Care Physician _____ Last Visit _____ Referred by _____

Preferred Local Pharmacy _____ **Telephone** _____

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Other ☐ Decline to disclose
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to disclose

I hereby give Barrett Podiatry physicians and associates permission to examine and treat my feet. I also assign to Barrett Podiatry all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance. I also authorize release of medical information necessary to process any health insurance claims. If my primary treating provider is no longer affiliated with Barrett Podiatry. I hereby give Barrett Podiatry the option to release to such provider a copy of my health record. A copy of my signature on file will be considered as valid as the original. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) the Notice.

Signature _____ **Today's Date** _____

Print Patient Name/Parent of minor _____

Financial Policy

We are committed to providing you the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. All patients must sign our Financial Policy prior to receiving treatment.

Insurance:

As a courtesy to our patients, we will file your claims to your insurance company. However, your insurance contract is between you and your insurance company. If your insurance company has not paid in full within 45 days of the service date, we will give you 15 days to bring your account current. Balance will be requested in full upon your next visit.
All deductibles, copayments, and coinsurance are due at the time of service.

Initial: _____

Any special ordered orthotics shoe insole, medicated bandages, or over the counter medication products are to be paid in full at time of service.

Missed Appointments/Late Appointments:

We require a 24-hour notice for appointment cancellations. Our fees for missed appointments or late cancellations are as followed:

1st missed appointment or late cancellations: $25.00

Any additional missed appointment or late cancellations: $50.00

Three or more missed appointments or late cancellations are grounds for dismissal from our services. We do understand on occasions unavoidable delays will prevent you from getting to your appointment on time. Due to nature of our work, we do not have the flexibility to assist patients beyond their scheduled appointment time. We ask that you show up 15 minutes prior to your scheduled time. You will be required to make payment in FULL for any missed or late appointments prior to seeing the physician.

Initial: _____

Collections:

In rare cases, when we are unable to collect any outstanding balances in our office, we may at our discretion use and outside collection agency/credit reporting service. A $50.00 service fee will be added to your account if we must utilize any outside agency.

Initial: _____

_____ _____

Responsible Party Signature Date

Barrett podiatry

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read) and understood the notice.

Patient Name (please print)	Signature	Date

Federal privacy laws limit our ability to communicate to your family and others regarding your care. If you wish to grant permission for us to disclose information to others, please indicate below.

You have the right to revoke this consent at any time.

☐ Do not disclose my information to anyone but myself

☐ You may disclose information to the following:

Name	Relationship
Name	Relationship

Barrett podiatry

Name: _____

Date: _____

Height: _____ Weight: _____

Please check (x) if you have ever had any of the following:

ALLERGIES

- ☐ **No Known Drug Allergies**
- ☐ Latex
- ☐ Local anesthetic
- ☐ Codeine
- ☐ Iodine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

MEDICAL HISTORY

- ☐ **Anxiety/ Depression**
- ☐ **Arthritis**
  - ☐ Degenerative
  - ☐ Fibromyalgia
  - ☐ Rheumatoid
  - ☐ Other: _____
- ☐ **Asthma**
- ☐ **Blood Disorder**
  - ☐ Anemia
  - ☐ Clotting Disorder
- ☐ **Cancer**
  - ☐ Bladder
  - ☐ Breast
  - ☐ Cervical
  - ☐ Colon
  - ☐ Lung
  - ☐ Leukemia
  - ☐ Myeloma
  - ☐ Lupus
  - ☐ Prostate
  - ☐ Skin
  - ☐ Other: _____
- ☐ **Circulation Problems**
  - ☐ Phlebitis
  - ☐ Varicose Veins
  - ☐ Peripheral Vascular Veins Dis.
  - ☐ Stroke
- ☐ **Diabetes**
  - ☐ Insulin Dependent
  - ☐ Adult Onset
  - ☐ Well Control
  - ☐ Not Control
- ☐ **Ear / Eye Trouble**
  - ☐ Blurred Vision
  - ☐ Cataracts / Glaucoma
- ☐ **Elevated Cholesterol**
- ☐ **Gout**
- ☐ **Heart Trouble**
  - ☐ Atrial Fibrillation
  - ☐ Coronary Artery Disease
  - ☐ Irregular Heartbeat
  - ☐ Mitral Valve Prolapse
  - ☐ Tachycardia
- ☐ **Herniate Disc**
- ☐ **High Blood Pressure**
- ☐ **HIV Positive**
- ☐ **Intestinal Problems**
  - ☐ Acid Reflux
  - ☐ Chron's Disease
  - ☐ Irritable Bowel
  - ☐ Stomach Ulcers
  - ☐ Dialysis
  - ☐ Transplant
- ☐ **Liver Disease**
  - ☐ Hepatitis
  - ☐ Fatty Liver
- ☐ Peripheral Neuropathy
- ☐ Prolonged Bleeding
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: _____

FAMILY HISTORY

Applies to Parents, Grandparents or Siblings.

- ☐ **No Family Medical History**
- ☐ Diabetes
- ☐ Cancer
- ☐ Foot Problems
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Obesity

SOCIAL HISTORY

- ☐ No Current Alcohol Use
- ☐ Social Use
- ☐ Prior History of Alcohol Abuse
- ☐ Alcohol Consumption 1-3 Per Week
- ☐ Alcohol Consumption 4+ Per Week

- ☐ No Prior History of Tobacco/Smoking
- ☐ Prior History of Tobacco/Smoking
- ☐ Occasional Use of Tobacco Products
- ☐ Current Use of Tobacco Products

- ☐ No Prior/Current Drug Abuse
- ☐ Prior History of Drugs
- ☐ Prior History of IV Drug Abuse
- ☐ Current Drug Abuse

MEDICATIONS

☐ **None** ☐ **List Attached**

_____

_____

_____

_____

_____

LIST SURGERY HISTORY

_____

_____

_____

_____

Barrett Podiatry
Intake Questionnaire

_____ _____
Printed Patient's Name Date of Birth

What is your primary foot complaint today? _____

When did this start? ____ days ____ weeks ____ months ____ years.

Has the problem gotten better, worse, or unchanged? _____

Was this trauma?	□ Yes	□ No
Does this affect your walking?	□ Yes	□ No
Does this affect your ability to exercise?	□ Yes	□ No
Does this affect your daily living?	□ Yes	□ No
Was this a job-related injury?	□ Yes	□ No

How would you describe your pain?
□ generalized □ localized □ throbbing □ radiating □ burning □ numbness □ dull ache □ sharp ache □ other

Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe) ____

What seems to aggravate your condition?

□ walking □ certain shoes □ exercise □ heat or cold □ standing □ running □ other: _____

Where is the problem? _____

What makes the problem better? _____

What makes the problem worse? _____

Have you had any previous treatments? _____

Have you self-treated with prescriptions or with non-prescriptions? _____

What is your occupation? _____

What size of shoe do you wear? _____

Have you recently change your shoe gear or activity? _____

What forms of treatment have you tried for your current condition?

□ No treatment □ Physical Therapy □ Custom Orthotics □ Over the Counter Orthotics □ Stretching

□ Ice □ Heat □ Shoes □ Injections □ Soaking □ Resting □ Elevation □ Compression □ Surgery

□ Other: _____

Are there any other questions or concerns you would like to discuss with the doctor?

_____