

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc.

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self Other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Practice: _____

Today's Date: _____

Name: _____ **Chart #:** _____ **Date of birth:** _____

Race: _____ I prefer not to answer I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ I prefer not to answer I do not know

Preferred Language: _____ I prefer not to answer

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City, State, Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other: _____

Name(s): _____

Smoking Status

Current Every Day Smoker Never Smoker

Current Some Day Smoker I decline to answer

Former Smoker

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications

I take the following prescriptions/over the counter medications:

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Use the back of this form if more room is needed

Allergies

No Known Allergies

No Known Drug Allergies

	Reaction
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Tape	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Betadine (iodine)	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol™	_____
<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Other (specify)	_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. *(Release of Information):* I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History):* I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

<input type="checkbox"/> Liver	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA	
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Stroke		

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE	
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency		
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE	
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE	
Integumentary	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches	
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE	
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis	<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE	

PLEASE READ AND SIGN

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Patient Signature: _____ Date: _____

Andrew D. Hewchuck, D.P.M. Financial Policy

The following is a statement of Dr. Hewchuck's Financial Policy, which we request you read and sign prior to any treatment.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. We do not bill secondary insurance programs. If you have traditional Medicare and another secondary insurance, Medicare is expected to automatically bill your secondary insurance. Additionally, not all secondary insurance covers deductibles and copayments. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment. We offer a 15% discount if your balance is paid in full at the time of service. A payment plan of no more than three months may be arranged, in which case you must sign a Payment Plan Agreement.

PAYMENTS: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by cash, check or credit card (Visa, MasterCard, Discover). There will be a \$35.00 charge for returned checks.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment. Per our contract with the insurance carriers, we are required to collect co-payments prior to billing the insurance company.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

DELINQUENT ACCOUNTS: Any outstanding patient balances 30 days or more will be forwarded to our collection department. A 33.33% fee will be added to the balance by our collection department. The 33.33% will be paid by the patient, in addition to any court costs or fees if applicable.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge a fee of \$45.00 for missed appointments.

ORTHOTIC DEVICES: Custom orthotics are a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotic benefits. A deposit of 50% is required at the time of the examination and casting and the remaining balance is due when the orthotics are dispensed. Non-custom orthotics are not billable to insurance.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items.

Name (Print): _____

Patient Signature

Date