Advanced Podiatry Demographic & Primary Complaint Form

It is a requirement of the federal government that this information be collected on each new patient and updated yearly for existing patients. Thank you for your cooperation, Dr. Cupp and Staff.

Name _____Age_____DOB_____
First Middle Last

Address _____City_____State_____ZIP_____

Primary Phone_____Other Phone_____ Social Sec_____ Sex ☐F ☐M

Marital Status ☐S ☐M ☐W ☐D ☐Sep Patient's Employer/School_____ Phone _____

Primary Language _____ Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Race: ☐White ☐Native American ☐Asian ☐Black/African American ☐Native Hawaiian/other Pacific Islander ☐Other

Email address_____

Spouse/Parent/Legal Representative Information: (please also include this person on HIPAA form)
Name _____ Phone _____

Address _____ Employer _____

Emergency Contact Name _____ Phone _____

Insurance Information:
Primary _____ Policy Number _____ Group _____

Secondary _____ Policy Number _____ Group _____

Tertiary _____Policy Number _____ Group _____

What is your primary foot complaint today? _____

When did this start? ____ days ____ weeks ____ months ____ years Is the problem getting better/worse/unchanged?

Was this a result of trauma? Yes No
Does this affect your walking? Yes No
Does this affect your ability to exercise? Yes No
Does this affect your daily activity? Yes No
Was this a job-related injury? Yes No If yes, when did injury occur? _____

How would you describe your pain? (circle all that apply)
generalized localized throbbing radiating burning numbness dull ache sharp ache other

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

What treatments have you tried for this problem? _____

Do you have any other foot problems? _____

I hereby give my permission to Nicole Cupp, DPM, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis, and/or treatment of my foot condition. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

➔Signature:_____ Date: _____

Advanced Podiatry Patient History Form

PERSONAL INFORMATION:

Patient Name _____ Age _____ DOB _____

Current Weight _____ Height _____ Shoe Size _____

Primary Care Physician _____ Date last seen _____

Referring Physician _____ Have you had a flu shot *this year*? ☐ Yes ☐ No
Have you had a pneumonia shot? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Are you Diabetic? ☐ Yes ☐ No Do you use insulin? ☐ Yes ☐ No Date of Diagnosis _____ Last A1C reading _____

Do you/have you had the following? Hepatitis ☐ Yes ☐ No HIV/AIDS? ☐ Yes ☐ No

Check each line	Yes	No	Check each line	Yes	No	Check each line	Yes	No
Amputation	____	____	COPD/Emphysema	____	____	Mitral valve prolapse	____	____
Anaphylactic reaction	____	____	Cysts	____	____	Neuropathy	____	____
Anesthesia reaction	____	____	Cystic fibrosis	____	____	Osteopenia	____	____
Anxiety disorder	____	____	Depression	____	____	Osteoporosis	____	____
Arthritis	____	____	Diabetes mellitus	____	____	Pacemaker	____	____
Asthma	____	____	Fibromyalgia	____	____	Peripheral vascular disease	____	____
Atrial fibrillation	____	____	Gout	____	____	Psoriasis	____	____
Back pain	____	____	Heart disease	____	____	Pulmonary embolism	____	____
Birth control use	____	____	High cholesterol	____	____	Reflux/heartburn	____	____
Blood clot history	____	____	High blood pressure	____	____	Rheumatoid arthritis	____	____
Broken bone	____	____	Hyperthyroidism	____	____	Seizure disorder	____	____
location _____			Hypothyroidism	____	____	Skin ulcers	____	____
Cancer	____	____	Irritable bowel syndrome	____	____	Sleep apnea/CPAP	____	____
Chemical addiction	____	____	Kidney disease	____	____	Stomach ulcers	____	____
Circulation problems	____	____	Large scars/keloids	____	____	Stroke	____	____
Clostridium Difficile Colitis	____	____	Liver condition	____	____	Tuberculosis	____	____
Congestive Heart Failure	____	____	Melanoma	____	____	Other_____		
			Menopause	____	____	_____		

List all medications you take INCLUDING THE DOSAGE AND HOW OFTEN YOU TAKE IT. (include aspirin, birth control pills, over the counter medications and supplements) **IF YOU HAVE A LIST, WE CAN MAKE A COPY.**

Medication	Dosage	How often?	Medication	Dosage	How often?
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Pharmacy_____ **Location** _____

ALLERGIES (please check)

	Yes	No	If yes, list reaction
Tapes/Adhesives	____	____	_____
Eggs	____	____	_____
Iodine	____	____	_____
Latex	____	____	_____
Nickel/metal jewelry	____	____	_____
NSAIDS/anti inflammatories	____	____	_____

	Yes	No	If yes, list reaction
Penicillin	____	____	_____
Shellfish	____	____	_____
Sulfa Drugs	____	____	_____
X-ray dye	____	____	_____

Others _____
_____

Patient History Form Continued

PREVIOUS SURGERIES: (include any complications)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please check ALL that apply

Alcoholism	____	Heart problems	____
Amputation	____	kidney disease	____
Anesthesia problems	____	Liver problems	____
Arthritis	____	Lupus/autoimmune disease	____
Bleeding disorders	____	Malignant melanoma	____
Blood clots	____	Neurologic disease	____
Bunions/foot deformity	____	Peripheral vascular disease	____
Cancer	____	Pulmonary embolism	____
Diabetes mellitus	____	Rheumatoid arthritis	____
Heart disease	____	Other _____	

SOCIAL HISTORY: (circle)

Smoking Status:	Non-smoker	Former Smoker	Current Smoker
Alcohol Use:	Non-drinker	Social Drinker	Daily Use
Illegal Drug Use:	Never Used	Former User	Current User

Occupation _____ Hours per shift on your feet _____

REVIEW OF SYSTEMS: Please circle any CURRENT symptoms you are experiencing

Systemic	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
Cardiovascular	Chest pain Shortness of breath	None
Motor	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
Neurological	Numbness in feet Leg pain Back pain Para theses (nerve sensations)	None
Derm	Rash Masses Skin color changes Itching	None
Vascular	Calf/leg cramps at night Calf/leg cramps while walking Edema (swelling of legs) Cold fingers/toes Cold intolerance	None

*Please note: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

If you would like a copy of your continued care document from today, please inform the front office.

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

➔**Signature**: _____ **Date**:_____

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash, check, VISA, MasterCard, Discover, or American Express. **Any copays must be paid at the time of check-in; if you do not have your copay, your appointment will need to be rescheduled.**
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you; insurance benefits are paid directly to the doctor. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible.
- All health plans are not the same and do not cover the same services. **In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered**. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Patient Name: _____DOB_____

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Date: _____ _____ Patient initials to indicate copy received

Name _____ DOB _____ Primary Care Doctor _____

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by this office and are accessible to office personnel. Office personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This office and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the office's charges and to any health care provider who is or may become involved with my care. Oklahoma/Kansas law requires that this office advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Office personnel may release my general condition to family or friends who inquire about me by name and are listed in the Release of Protected Health Information below.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY

I understand that this office will assist with precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this office.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____ _____ _____ _____

Patient Signature (or patient's legal representative) Relationship to Patient Date Signed Witness

_____

Patient Name (please print)

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

_____ _____ _____

Name Relationship Phone Number

_____ _____ _____

Name Relationship Phone Number

_____ _____ _____

Name Relationship Phone Number

Please check the appropriate box:

☐ I authorize or ☐ do not authorize limited confidential medical messages to left on my:

Home Phone #_____ or Cell Phone #_____ or Work #_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this office is in our NOTICE OF PRIVACY PRACTICES. A copy is available in our office.

I have been made aware of the Notice of Privacy Practices.

_____ _____ _____ _____

Patient Signature (or patient's legal representative) Relationship to Patient Date Signed Witness