Advanced Foot Care Center

204 Grove Ave. Suite G Thorofare, NJ 08086 856-579-8674

PATIENT INFORMTION: Please Complete ALL Information (use **BLACK** ink only)

Name:_____ **SSN:**_____ **DOB:**_____ **Age:** _____

Height_____ **Weight**_____ **Shoe Size** _____ **Marital Status:** S M D W **Gender:** M F

Vital Signs: **BP**_____ **Pulse**_____ **Respiration Rate**_____ **Temperature** _____

Mailing Address:_____ **City/State**_____ **Zip Code**_____

Home Ph:_____ **Work Ph:**_____ **Cell:**_____

Email Address: _____

Race: American Indian/Alaskan Native, Asian, Black/African American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, White

Language: What language do you primarily speak in your home? English Spanish Other:_____

Whom may we thank for referring you to us: Newspaper, Friend, Relative, Physician, Insurance, Internet, Other
Name of Individual: _____

Chief complaint for which you came to be treated:_____

Personal or family history of diabetes: Y N **Other Family History**_____

Have you ever been to a podiatrist before? _____

If yes, please list Name:_____ **Last visit date:**_____

Cigarette/Tobacco Use: Never Smoker Former Smoker Current Smoker (Packs/day_____ Years_____)

Current Pharmacy: (Name, city and street) _____

FINANCIAL INFORMATION:

Occupation: _____ **Employer:** _____
Primary Insurance: _____ **Secondary Insurance:** _____
Spouse Name: _____ **Date of Birth:** _____
Emergency contact: _____ **Phone Number:** _____

AUTHORIZATION: I hereby authorize Advanced Foot Care Center to render and provide any such evaluation, management and treatment of my podiatric medical condition. I also authorize Advanced Foot Care Center to furnish my protected health information to Insurance companies, Medicare carriers, my employer, or laboratories concerning my illness. I hereby assign to the physician all payments for medical services rendered to myself or my dependents.

By signing below, you acknowledge that it is your responsibility to understand all benefits, limitations and provisions of your health insurance plan. You understand that you are responsible for any amount not covered by insurance. Your health insurance policy is a contract between you & your insurance company. Any insurance deductibles are your responsibility. These include items such as copayments, coinsurances and deductibles (Your Medicare secondary insurance may not cover it). Furthermore, you agree by signing below that any and all treatments provided to you or your dependents today in absence of a referral and/or authorization (should they be required) will result in your full financial responsibility. You also acknowledge that you may be refused to be seen without a referral if one is required by your insurance and it was not obtained by you prior to your arrival for treatment. Any out of pocket expenses require full payment at time of service however, other arrangements can be made for payment. Co-pays are due at time of service. Also, by signing below you acknowledge that should you not pay your balance after several reasonable attempts by our staff to collect the balance owed or make payment arrangements, your account will be sent to a collection agency in compliance with the rules of the Fair Debt Collection Act (FDCA). Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Date: _____ **Signature:** _____

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CURRENT CONDITION SURVEY

Name: _____ **Date:** _____

What is your current foot/ankle/lower leg problem? **Right** **Left** **Both**

_____

_____

Describe the symptoms you are having:

_____

_____

Which of the following best describes the type of pain you are having? (circle all that apply)

Burning	Tingling	Sharp	Stabbing	Stinging	Numbness	Aching	Dull
Constant	Intermittent	Cramping	Excruciating	Annoying	Itching	Radiating	

How Severe is the pain?

On a scale of 1-10, how would you rate your pain? (1=no pain and 10=worst pain of your life) _____

Mild Mild to Moderate Moderate Moderate to Severe Severe

Describe any recent trauma or injury to your foot/ankle. How did you hurt yourself?

_____

_____

Is the condition chronic? Yes No

Have you been treated for this problem before? If so, what treatment and by whom?

_____

How long has the pain been present? When did it start?

_____

How did the condition develop? Gradually Suddenly At the time of injury Unknown

What makes the condition better or worse? Any self-treatment?

_____

_____

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REVIEW OF SYSTEMS (Check all that apply)

Constitutional
- ☐ Fever
- ☐ Fainting
- ☐ Dizziness
- ☐ Headache
- ☐ Weakness
- ☐ Weight Loss
- ☐ Difficulty reading or writing (Ask, we will help you)
- ☐ None

Eyes
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double vision
- ☐ Dry Eyes
- ☐ Glaucoma
- ☐ None

Ears, Nose Throat and Mouth
- ☐ Convulsions
- ☐ Cough/Cold
- ☐ Difficulty Hearing/Hearing Aid
- ☐ Migraines
- ☐ Nose Bleeds
- ☐ Teeth or Gum Problems
- ☐ None

Cardiovascular
- ☐ Blood Clots/Phlebitis
- ☐ Chest pain
- ☐ Edema
- ☐ Heart attack/MI
- ☐ Hypertension
- ☐ Murmur/MVP/Arrhythmia
- ☐ Night cramps/leg cramps
- ☐ Palpitations
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ None

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ Sleep apnea
- ☐ None

Gastrointestinal
- ☐ Abdominal cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach ulceration/GI ulceration
- ☐ GI upset with anti-inflammatory medications (NSAIDs)
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Celiac Disease/Gluten intolerance
- ☐ None

Genitourinary
- ☐ Blood in Urine/Dark Urine/Discolored Urine
- ☐ Increased/Frequent Urination
- ☐ Painful Urination
- ☐ Yeast Infections
- ☐ Discharge
- ☐ Prostate Issues
- ☐ Menopause / Currently Menstruating
- ☐ None

Musculoskeletal
- ☐ Arthritis
- ☐ Chronic neck, back, hip pain
- ☐ Joint pains/aches
- ☐ Foot/Ankle fracture(s)
- ☐ Tendon Injury
- ☐ Sprain/Strain
- ☐ Stiffness
- ☐ Gout
- ☐ Osteoporosis/Osteopenia
- ☐ Foot pain
- ☐ Heel Pain
- ☐ Ankle Pain
- ☐ Leg Pain.
- ☐ Pain with first step out of bed in the morning
- ☐ Assistive device to walk
- ☐ Pain in shoes or bare foot
- ☐ Weakness
- ☐ None

Integument/Skin
- ☐ Itching
- ☐ Keloid formation
- ☐ Rash
- ☐ Scaling
- ☐ Skin cancer
- ☐ Dermatitis
- ☐ Callus/Corn(s)
- ☐ Wart
- ☐ Ulcer(s), Non-healing wounds, poor or slow healing
- ☐ Athlete's foot
- ☐ Eczema
- ☐ None

Neurological
- ☐ Burning in feet, heel, ankle, lower leg or back
- ☐ Numbness
- ☐ Sciatica
- ☐ Tingling
- ☐ Vertigo
- ☐ Seizures
- ☐ Dementia/Memory loss
- ☐ Tremors
- ☐ Spastic
- ☐ Attention Deficit/Hyperactive Disorder
- ☐ None

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Bipolar
- ☐ Post-Traumatic Stress
- ☐ Chemical dependency
- ☐ None

Endocrine
- ☐ Elevated blood sugar. Last blood sugar level _____
- ☐ Excessive eating or drinking
- ☐ Over active or underactive thyroid
- ☐ None

Hematological/Immunological
- ☐ Allergies to medications
- ☐ Seasonal allergies
- ☐ Bruise easily
- ☐ On blood thinners
- ☐ Leukemia
- ☐ Sickle Cell Anemia
- ☐ Anemia
- ☐ None

All others reviewed by Dr. Megara on _____ and found non-contributory. _____

MEDICAL HISTORY (Please check yes or no):

AIDS/HIV	□ Yes □ No	Fainting	□ Yes □ No	Respiratory Disease	□ Yes □ No
Anemia	□ Yes □ No	Foot/Leg Cramps	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Arthritis	□ Yes □ No	GI Issues	□ Yes □ No	Shortness of Breath	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Gout	□ Yes □ No	Sinus Problems	□ Yes □ No
Artificial Joints	□ Yes □ No	Headaches	□ Yes □ No	Stroke	□ Yes □ No
Asthma	□ Yes □ No	Heart Disease	□ Yes □ No	Swelling Feet/Ankles	□ Yes □ No
Back Problems	□ Yes □ No	Hemophilia	□ Yes □ No	Swollen Glands	□ Yes □ No
Bleeding Problems	□ Yes □ No	Hepatitis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Tired Feet	□ Yes □ No
Chemical Dependency	□ Yes □ No	High Cholesterol	□ Yes □ No	Tuberculosis	□ Yes □ No
Chest Pain	□ Yes □ No	Kidney Problems	□ Yes □ No	Ulcers	□ Yes □ No
Circulatory Problems	□ Yes □ No	Liver Problems	□ Yes □ No	Varicose Veins	□ Yes □ No
Clotting Problems	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Venereal Disease	□ Yes □ No
Diabetes	□ Yes □ No	Nervous Problems	□ Yes □ No		
Epilepsy	□ Yes □ No	Psychiatric Care	□ Yes □ No		
Eye Problems	□ Yes □ No	Radiation Treatment	□ Yes □ No		

Surgeries you have had:_____

Hospitalizations, other than for the surgeries:_____

Family Physician:_____ **Last Visit Date:**_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Y N
If yes, please explain:_____

MEDICATIONS (prescriptions, over-the-counter & vitamins. You may provide a list also if you have one.)

_____ _____ _____

_____ _____ _____

ALLERGIES/REACTION

○ Adhesive Tape ○ Aspirin ○ Codeine ○ Demerol ○ Iodine ○ Local Anesthetics ○ Novocain
○ Penicillin ○ Seafood ○ Sulfa Drugs ○ None ○ Other_____

CONSENT/HIPAA NOTICE OF PRIVACY PRACTICES

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

I authorize Advanced Foot Care Center to use and disclose the protected health information for both treatment and for payment of services rendered by all doctors of Advanced Foot Care Center. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

Patient Signature _____ **Date**_____

Signature on File

1. I authorize the use of this form on all insurance claim submissions on my behalf;

2. I authorize the release of all pertinent medical information to my insurance carrier to facilitate payment of medical claims submitted on my behalf;

3. I understand that, ultimately, I am responsible for fees associated with my treatment;

4. I authorize Advanced Foot Care Center to act as my agent in obtaining fees for services rendered to me;

5. I authorize the release of payment whether payable to me or Advanced Foot Care Center .

6. I authorize Advanced Foot Care Center to use this form in place of my original signature;

7. I understand that any co-pays and/ or deductibles are due at the time of my appointment;

8. I understand that I must provide all the necessary authorizations and/or referrals, should my plan require it, at the time of service;

9. I further understand that should I not provide valid referral and/or authorization, I will be responsible for the cost of the visit. Any costs associated with the visit will be disclosed to me prior to any treatment being rendered.

I HAVE READ THE ABOVE STATEMENTS AND I UNDERSTAND AND AGREE WITH ITS TERMS.

_____
PRINT NAME

_____
SIGNATURE OF RESPONSIBLE PARTY

_____
DATE

---PLEASE TURN OVER PAGE---

ADVANCED FOOT CARE CENTER

We accept assignment on most insurance benefit plans. However, on certain occasions your insurance company may send the check directly to you. In such an event, please sign the back of the check and immediately bring it to the office where you were seen. Should you not do so, you will become liable for the entire amount billed to your insurance carrier.

Thank you for understanding our Out of Network Financial Policy. Should you have any questions regarding this policy, please feel free to discuss it with us at any time.

I have read the Out of Network Financial Policy and understand and agree to this policy.

Print_____ **Signature**_____ **Date**_____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

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