

Welcome to Coastal Podiatry

PATIENT INFORMATION	
(PLEASE PRINT)	Date: _____
Patient: _____	
Address: _____	
City _____ State _____ Zip _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Patient's SS#: _____	
Occupation: _____	
Employer: _____	
Employer Address: _____	
City _____ State _____ Zip _____	
Spouse's Name: _____	
INSURANCE INFO (If Different From Patient)	
Subscriber's Name: _____	
Birthdate: _____ SS#: _____	
Relationship to Patient: _____	
PHONE NUMBERS	
Home: _____ Work: _____ ext _____	
Best time & place to reach you: _____	
In Case of Emergency, Contact:	
Name _____	
Relationship: _____	
Home Phone: _____	
Work Phone: _____ ext _____	
FINANCIAL RESPONSIBILITY	
I agree to be financially responsible for the cost of all medical and / or surgical services rendered to the patient by Coastal Podiatry, Inc. Coastal Podiatry will submit your claim to your insurance company. However, if payment is not received within 60 days, a bill will be sent to the responsible party for full payment. I also hereby authorize release of medical records to any company insuring the above patient and assign all benefits from insurance to Coastal Podiatry, Inc., for professional services provided. If payment for these services is not made when agreed upon, in addition to the physician's fees, I agree to pay all costs of collecting the amount due with interest from the due date. Costs include: attorney's fees or collection agency fees of 50% of the total amount due, and all court costs expended in the collection of this medical bill. By my signature, I acknowledge that I have read and understood the terms of this agreement.	
INSURANCE REFERRALS	
Many companies require that you obtain a written referral from your primary care physician prior to your visit. If a referral is not received at time of the appointment, then your insurance may not pay for the visit and you will be responsible for any fees incurred. Please review your insurance company's policies.	

RESPONSIBLE PARTY	
PERSON responsible for this account? _____	
Address: _____	
City _____ State _____ Zip _____	
Relationship to Patient: _____	
Responsible Party Signature _____	Date _____
REFERRED BY	
How did you hear of us? (Please check all that apply)	
<input type="checkbox"/> Primary Doctor	<input type="checkbox"/> Friend
<input type="checkbox"/> Family Member	<input type="checkbox"/> Phone Book
<input type="checkbox"/> Lecture Given by Our Doctor	
<input type="checkbox"/> Passing by Our Location	
<input type="checkbox"/> Other: _____	
Whom may we thank for referring you? _____	
Address: _____	
City _____ State _____ Zip _____	
MEDICARE PATIENTS ONLY	
MEDICARE AUTHORIZATION	
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Podiatry Group for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services or items. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.	
Beneficiary Signature _____	Date _____
CANCELLATION POLICY	
<u>We require at least 24 hours notice to cancel or reschedule an appointment. Otherwise, a \$25.00 fee will be charged to you.</u>	
Proper notification of canceled appointments will allow us to schedule someone waiting on the "cancellation list". The other patient and we thank you.	

Responsible Party Signature _____ Date _____

Patient Name: _____
 Family physician: _____ Last visit date _____
 Has he or she requested that you be seen in our office? Yes No
 What problems bring you to our office? _____

MEDICAL HISTORY					
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarring Tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain or Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers/Stomach problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how much?	_____	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		If yes, how much?	_____		

MEDICATIONS
Include prescriptions, over-the-counter medications & vitamins:
Pharmacy Name(s) _____
Pharmacy Phone(s) _____
Do you take oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No

ALLERGIES	
<input type="checkbox"/> Adhesive / Tape	<input type="checkbox"/> Latex
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Demerol	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa
Other _____	

Surgeries you have had (include date, physician, hospital) _____

Hospitalization other than for the surgeries listed above _____

Does any of your immediate relatives have any of the following diseases:			Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental/Emotional Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden Death	<input type="checkbox"/> Yes <input type="checkbox"/> No

Women Patients: Are you pregnant? Yes No If so, how many months? _____

CONSENT
I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.
Patient's Signature (or Responsible Party): _____
Date: _____