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PATIENT INFORMATION

DATE: _____

NAME: _____ M / F

BIRTH DATE: _____ AGE: _____ PHONE: _____

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

EMAIL ADDRESS: _____

OUT OF STATE ADDRESS: _____

EMPLOYER NAME: _____ WORK PHONE: _____

EMPLOYEE ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

SOCIAL SECURITY #: _____

HOW DID YOU LEARN ABOUT OUR OFFICE? _____

PRIMARY PHYSICIAN: _____ PHONE #: _____

EMERGENCY CONTACT CITY/STATE: _____

(To be notified in case of emergency. Someone NOT living with you).

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ WORK PHONE: _____

HOME ADDRESS: _____

PHARMACY: _____ LOCATION: _____

RESPONSIBLE PARTY INFORMATION

(Person responsible for paying any balance not covered by insurance).

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ DOB: _____ SSN #: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURANCE PHONE NUMBER: _____ EFFECTIVE DATE: _____

NAME OF INSURED PERSON: _____

CO-INSURANCE PERCENTAGE OR CO-PAY AMOUNT: _____

ANNUAL DEDUCTIBLE: _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURANCE PHONE NUMBER: _____ EFFECTIVE DATE: _____

NAME OF INSURED PERSON: _____

RELEASE OF INFORMATION/INSURANCE ASSIGNMENT

DO WE HAVE PERMISSION TO?	YES	NO
LEAVE A MESSAGE ON YOUR HOME ANSWERING MACHINE?		
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?		
DISCUSS YOUR MEDICAL CONDITION WITH ANY FAMILY MEMBERS?		
IF YES, WITH WHOM?		

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES I HAVE BEEN PROVIDED. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AUTHORIZE BRUCE B. LEVIN DPM PA TO APPLY FOR BENEFITS ON MY BEHALF FOR ANY COVERED SERVICES. I REQUEST THAT PAYMENT FROM THE INSURANCE COMPANY BE MADE DIRECTLY TO BRUCE B. LEVIN DPM PA. I AUTHORIZE BRUCE B. LEVIN DPM PA TO CONTACT AND FORWARD ANY PERTINENT MEDICAL INFORMATION TO MY OTHER PHYSICIAN FOR THEIR RECORDS. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE COMPANY.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT SIGNATURE: _____ **DATE:** _____

SOCIAL HISTORY

	YES?	NO?
DO YOU SMOKE?		
DO YOU DRINK?		

IF YES, NUMBER OF PACKS PER DAY? _____

IF YES, NUMBER OF OUNCES YOU DRINK PER WEEK? _____

DOES YOUR WORK OR LIFESTYLE INVOLVE SPENDING LARGE AMOUNTS OF TIME ON YOUR FEET? _____ EXPLAIN: _____

OCCUPATION: _____

DO YOU EXERCISE? _____ IF YES, HOW MUCH AND HOW OFTEN? _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF?

	YES?	NO?	WHO?
DIABETES			
HEART DISEASE			
BLOOD CLOTS			
BLEEDING PROBLEMS			
STROKE			
GOUT			
RHEUMATOID ARTHRITIS			

MEDICATIONS

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) THAT YOU TAKE ON A REGULAR BASIS AND WHY.

MEDICATION	MILLIGRAMS	HOW OFTEN	WHY

ALLERGIES

	YES	NO		YES	NO
PENICILLIN			CODEINE		
ASPIRIN			OTHER		
IODINE					
SULFA					
ADHESIVE TAPE					
NOVOCAIN					
SHELLFISH					
LATEX					

PATIENT MEDICAL HISTORY

LOCAL PHYSICIAN: _____ LAST VISIT: _____

PRIMARY LANGUAGE: _____

ETHNICITY: _____ RACE: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

WHAT TYPE OF FOOT PROBLEM BRINGS YOU TO OUR OFFICE?

PAST MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
DIABETES			COPD/EMPHYSEMA		
ABNORMAL HEART CONDITON			ASTHMA		
HEART ATTACK			STROKE		
MITRAL VALVE PROLAPSE			SEIZURES OR EPILEPSY		
VASCULAR DISEASE/BAD CIRCULATION TO FEET			KIDNEY DISEASE		
ABNORMAL BLOOD PRESSURE			LIVER DISEASE		
LUNG DISEASE			HEPATITUS		
STOMACH ULCERS			THYROID DISEASE		
ARTHRITIS/OSTEOARTHRITIS			RHEUMATOID ARTHRITIS		
GOUT			NEUROPATHY/NUMBNESS		
ARTIFICIAL JOINTS			DIFFICULTY IN HEALING		
CANCER			HIV		
OTHER:					

PLEASE DESCRIBE ANY OTHER MEDICAL PROBLEMS INCLUDING FOOT PROBLEMS THAT YOU HAVE ENCOUNTERED.

FOR WOMEN ONLY: ARE YOU PREGNANT? _____ IF SO, HOW MANY MONTHS? _____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

PLEASE GIVE ANY DETAILS OF ANY:

OPERATIONS/SERIOUS INJURIES	APPROXIMATE DATE WHEN OCCURRED	PHYSICIAN	HOSPITAL

PLEASE PLACE A CHECK NEXT TO ANY PROBLEMS YOU MAY BE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

CONSTITUTIONAL

____ DECREASE IN APPETITE, ____ FAINTNESS, ____ FEVER, ____ HEADACHE,
 ____ FEELING ROOM SPINNING, ____ WEAKNESS, ____ WEIGHT LOSS,
 ____ WEIGHT GAIN, ____ NONE

COMMENTS: _____

SKIN/NAILS

____ ALLERGIC TO CHEMICALS, ____ THICK OR DISCOLORED TOENAILS, ____ SKIN DRYNESS,
 ____ THICK OR DISCOLORED FINGER NAILS, ____ SCARRING AFTER SURGERY/INJURY,
 ____ SKIN ITCHING, ____ SKIN CRACKING, ____ SKIN CANCER, ____ NONE

COMMENTS: _____

MUSCULOSKETAL

____ JOINT ACHES OR PAINS, ____ CHRONIC NECK PAIN, ____ CHRONIC HIP OR KNEE PAIN,
 ____ CHRONIC LOWER BACK PAIN, ____ CHRONIC ANKLE PAIN, ____ STIFFNESS,
 ____ SWELLING IN JOINTS, ____ MORNING SICKNESS, ____ PAIN UPON RISING IN THE
 MORNING OR AT ANY TIME, ____ NONE

COMMENTS: _____

CARDIOVASCULAR

____ CHEST OR ARM PAIN, ____ BLOOD CLOTS, ____ CRAMPS IN LEGS OR FEET WHEN
 WALKING, ____ HIGH BLOOD PRESSURE, ____ LOW BLOOD PRESSURE, ____ CRAMPS
 WHEN SLEEPING IN LEGS OR FEET, ____ HEART ATTACK, ____ HEART MURMUR,
 ____ HEART PALPITATIONS, ____ STROKE, ____ VARICOSE VEINS, ____ MITRAL VALVE
 PROLAPSE, ____ NONE

COMMENTS: _____

NEUROLOGIC:

____ TINGLING, ____ PINS AND NEEDLES, ____ NUMBNESS, ____ BURNING
 ____ INCREASED SENSITIVITY TO TOUCH, ____ DECREASE OR LACK OF SENSATION TO TOUCH
 ____ DECREASE OR LACK OF SENSATION IN COLD OR WARMTH, ____ SHOOTING PAIN
 ____ RADIATING PAIN, ____ NONE

COMMENTS: _____

ALLERGIC/IMMUNOLOGIC

____ LUMPS IN GROIN OR ARMPIT, ____ FEVER, ____ CHILLS, ____ NIGHT SWEATS

____ SORE THROAT, ____ COUGHING, ____ WHEEZING, ____ GENERAL FEELING OF BEING SICK, ____ NONE

COMMENTS: _____

ENDOCRINE

____ INCREASE OR DECREASE IN THIRST, ____ INCREASE OR DECREASE IN APPETITE,

____ INCREASE OR DECREASE IN URINATION, ____ WEIGHT LOSS OR GAIN,

____ DIABETES MELLITUS, ____ THYROID PROBLEM, ____ POST MENOPAUSE,

____ SENSITIVITY TO HEAT OR COLD, ____ NONE

COMMENTS: _____

RESPIRATORY

____ DIFFICULTY IN BREATHING, ____ COUGH, ____ COUGHING BLOOD, ____ WHEEZING,

____ SHORTNESS IN BREATH, ____ DIFFICULTY IN BREATHING WHEN LAYING FLAT,

____ WAKING UP SHORT OF BREATH, ____ NONE

COMMENTS: _____

EARS, NOSE, MOUTH, THROAT

____ HEADACHE, ____ CONVULSIONS, ____ DENTURES, ____ DIFFICULTY HEARING,

____ NOSE BLEEDS, ____ SORE THROAT, ____ MIGRAINES, ____ DRY MOUTH, ____ RUNNY NOSE,

____ DIFFICULTY SWALLOWING, ____ TEETH OR GUM PROBLEMS, ____ RINGING IN THE EARS,

____ FAINTING SPELLS, ____ NONE

COMMENTS: _____

EYES

____ BLURRED VISION, ____ DOUBLE VISION, ____ DRY EYES, ____ EYE INFECTIONS,

____ RUNNY OR DRAINING EYES, ____ NONE

COMMENTS: _____

GASTROINTESTINAL

____ ABDOMINAL CRAMPS, ____ INFLAMATION OF COLON, ____ CONSTIPATION, ____ DIARRHEA,

____ HEARTBURN, ____ DIFFICULTY SWALLOWING, ____ BLOOD IN STOOL, ____ HEMORRHOIDS,

____JAUNDICE, ____BLACK OR TARRY STOOLS, ____NAUSEA, ____VOMITING, ____NONE

COMMENTS: _____

GENITOURINARY

____INABILITY TO URINATE, ____PAIN OR URINATION, ____BURNING WHEN URINATING,

____BLOOD IN URINE, ____EXCESSIVE NUMBER OF TIMES URINATING AT NIGHT,

____DARK URINE, ____DECREASE IN AMOUNT OF URINE PRODUCED,

____INABILITY TO HOLD URINE, ____YEAST INFECTION, ____NONE

COMMENTS: _____

PSYCHIATRIC

____DEMENTIA, ____DEPRESSION, ____MANIC-DEPRESSION/BIPOLAR, ____MEMORY LOSS,

____CONFUSION, ____PANIC ATTACKS, ____OBCESSIVE COMPULSIVE DISORDER,

____PARANOIA, ____NONE

COMMENTS: _____

HEMATOLOGICAL/BLOOD

____HEMOPHILLA, ____ANEMIA, ____BRUSING EASILY, ____BLOOD TRANSFUSION REACTION,

____SICKLE CELL DISEASE OR TRAIT, ____LEUKEMIA, ____WEAKNESS,

____JAUNDICE OR YELLOW SKIN, ____NONE

COMMENTS: _____

IS THERE ANYTHING YOU WISH TO TELL YOUR PHYSICIAN PRIVATELY?

____YES ____NO

WHICH PHARMACY DO YOU USE? _____

LOCATION? _____

PATIENT SIGNATURE AND DATE

DPM REVIEWED, SIGN AND DATE

CHANGES NOTED AND DATED

PRACTICE REQUIREMENTS

THIS PRACTICE:

*IS REQUIRED BY FEDERAL LAW TO MAINTAIN THE PRIVACY OF YOUR PRIVATE HEALTH INFORMATION (PHI) AND TO PROVIDE YOU WITH THIS PRIVACY NOTICE DETAILING THE PRACTICE'S LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PHI.

* UNDER THE PRIVACY RULE, MAY BE REQUIRED BY STATE LAW TO GRANT GREATER ACCESS OR MAINTAIN GREATER RESTRICTIONS ON THE USE OR RELEASE OF YOUR PHI THAN WHICH IS PROVIDED FOR UNDER FEDERAL LAW.

*IS REQUIRED TO ABIDE BY THE TERMS OF THE PRIVACY NOTICE.

*RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS PRIVACY NOTICE AND TO MAKE THE NEW PRIVACY NOTICE PROVISIONS EFFECTIVE FOR YOUR ENTIRE PHI THAT IT MAINTAINS.

*WILL DISTRIBUTE ANY REVISED PRIVACY NOTICE TO YOU PRIOR TO IMPLEMENTATION.

*WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

EFFECTIVE DATE

*THIS NOTICE IS IN EFFECT AS OF 12/15/07.

PATIENT ACKNOWLEDGEMENT

*BY SIGNING MY NAME BELOW, I ACKNOWLEDGE RECEIPT OF A COPY OF THIS NOTICE, AND MY UNDERSTANDING AND MY AGREEMENT TO ITS TERMS.

PATIENT SIGNATURE

DATE

ARIZONA SPECIALTY FOOTCARE

FINANCIAL POLICY

THANK YOU FOR CHOSING US AS YOUR HEALTH CARE PROVIDER. WE STRIVE TO PROVIDE THE MOST UP-TO-DATE AND COST EFFECTIVE TREATMENT, THERAPY, AND PRODUCTS FOR YOUR FOOT AND ANKLE CARE. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT.

MEDICARE PATIENTS ARE REQUIRED TO MEET A **\$162.00** CALENDAR YEAR DEDUCTIBLE. IF YOU HAVE A SUPPLEMENTAL OR SECONDARY INSURANCE, PLEASE INFORM OUR STAFF PRIOR TO YOUR VISIT.

NON-COVERED MEDICAL SUPPLIES OR SERVICES MUST BE PAID IN FULL AT THE TIME OF THE VISIT.

INDEMNITY INSURANCE PLANS SUCH AS BLUE CROSS/BLUE SHIELD WILL BE BILLED. YOU WILL BE RESPONSIBLE FOR ANY CO-INSURANCE AND DEDUCTIBLE AMOUNTS. IF WE DO NOT RECEIVE PAYMENT WITHIN 90 DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS WHO ARE COVERED BY A COMMERCIAL INSURANCE CARRIER, WITH WHOM WE ARE NOT PRACTICING PHYSICIANS, WILL REMAIN REPSONSIBLE FOR THEIR BALANCE. WE WILL COURTESY BILL YOR CARRIER. IF WE DO NOT RECEIVE PAYMENT WITHIN **90** DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS THAT DO NOT HAVE MEDICAL INSURANCE WILL BE REQUIRED TO PAY FOR THEIR SERVICES RENDERED IN FULL ON THE DATE OF SERVICE. WE WILL TRY TO ACCOMMODATE PATIENTS BY SUPPLYING AN ESTIMATE PRIOR TO SEEING THE DOCTOR. PAYMENT PLANS ARE NOT ACCEPTED.

WE REQUIRE PAYMENT IN THE FORM OF CASH, MONEY ORDER, CHECK, OR VISA/MASTERCARD.

CREDIT CARD GUARANTEE AUTHORIZATION IS RECOMMENDED. PLEASE ASK THE RECEPTIONIST FOR FURTHER INFORMATION OR CONCERNS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINNCIAL POLICY.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE

SIGNATURE OF WITNESS

DATE

MEDICARE DEDUCTIBLE FOR 2011 IS NOW \$162.00

