

Bruce B. Levin DPM FACFAS
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PATIENT INFORMATION

DATE: _____

NAME: _____

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 CARE PHYSICIAN: _____ *Phonett:*

EMERGENCY CONTACT

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

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ WORK PHONE: _____

HOME ADDRESS: _____

EMPLOYER: _____

RESPONSIBLE PARTY INFORMATION

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

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ DOB: _____ SSN #: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

*PHARMACY:
ADDRESS:
TELE. #:*

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? _____

IF YES, PLEASE EXPLAIN: _____

OCCUPATION: _____

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

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

	YES?	NO?
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					

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 OR YELLOW SKIN 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 OBSSIVE 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

PATIENT SIGNATURE AND DATE

DPM REVIEWED, SIGN AND DATE

CHANGES NOTED AND DATED

**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 \$155.00 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
2010 IS NOW \$155.00**

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;

- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.