PODIATRIC ASSOCIATES OF NW OHIO, INC.

DATE_____

PATIENT HISTORY

PATIENT'S LAST NAME | FIRST NAME | MIDDLE | SOCIAL SECURITY NUMBER

ADDRESS | STREET | APT. NO. | CITY | STATE | ZIP

DATE OF BIRTH | AGE | SEX | MARITAL STATUS | HOME/CELL PHONE

EMPLOYED BY | EMPLOYERS ADDRESS | BUSINESS PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY | ID # | GROUP# | POLICY HOLDER EMPLOYER

POLICY HOLDER NAME | S.S.# | D.O.B. | RELATION TO PATIENT

HOME ADDRESS | CITY | STATE | ZIP | HOME PHONE

SECONDARY INSURANCE COMPANY | ID # | GROUP# | POLICY HOLDER EMPLOYER

POLICY HOLDER NAME | S.S.# | D.O.B. | RELATION TO PATIENT

HOME ADDRESS | CITY | STATE | ZIP | HOME PHONE

RACE:	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American	☐ Hawaiian or Pacific Islander
	☐ White	☐ Other	☐ Declined	
ETHNICITY:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Unknown	☐ Declined
LANGUAGE:	☐ Arabic	☐ Chinese	☐ English	☐ French
	☐ Japanese	☐ Spanish	☐ Vietnamese	

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

WERE YOU REFERRED BY A PHYSICIAN'S OFFICE? _____YES _____NO

WERE YOU REFERRED BY A PATIENT OF OURS? _____YES _____NO

IF YES, NAME OF PATIENT OR PHYSICIAN REFERRING _____

IT IS OUR POLICY TO INFORM EACH PATIENT'S PRIMARY CARE PHYSICIAN CONCERNING THE TREATMENT GIVEN IN IN OUR OFFICE.

PRIMARY CARE PHYSICIAN _____ ADDRESS _____

I GIVE PERMISSION TO PODIATRIC ASSOCIATES OF NORTHWEST OHIO, INC. TO EXAMINE AND TREAT MY FEET AND ANKLES AND TO SUBMIT MY INCURRED CHARGES TO MY INSURANCE COMPANY

SIGNATURE _____ DATE _____

If you need help filling out this form, we will be happy to help. Just ask a member of our staff for assistance.

OVER

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION TO FAMILY AND FRIENDS

In order to comply with patient privacy regulations, including the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations on patient privacy and confidentiality, 45 C.F.R. Parts 160 and 164, I hereby authorize the use or disclosure of personal health information about me as described below.

1. I authorize the disclosure of my clinical health information by Podiatric Associates for the duration of my treatment.

2. Podiatric Associates may release my personal health information that is described above to the following person(s).

Name	Relationship	Home Phone	Cell Phone

I understand that I may revoke this authorization in writing at any time, except for the information that has already been disclosed by Podiatric Associates in reliance on this authorization, by sending a written revocation to Podiatric Associates, 609 Ford Street, Maumee, Ohio, 43537.

_____

Patient Name

_____ _____

Signature of Patient Date

_____

Name of Personal Representative (if applicable)

_____ _____

Witness Signature Date

PODIATRIC ASSOCIATES OF NW OHIO, INC.

PRINT NAME_____ **DATE**_____

MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

DESCRIBE YOUR FOOT/ANKLE PROBLEM _____

_____

_____

_____

How long has it been bothering you? _____Days _____Weeks _____Months _____Years

What treatment have you tried? _____

Any past problems of your feet and ankles? _____

_____

_____

Shoe Size _____ Current Weight _____ Current Height _____

CURRENT MEDICATIONS: (Including supplements)

1._____	6._____	11._____	16._____
2._____	7._____	12._____	17._____
3._____	8._____	13._____	18._____
4._____	9._____	14._____	19._____
5._____	10._____	15._____	20._____

Name of your Pharmacy _____ Phone# _____

ALLERGIES:

1. Antibiotics (Penicillin, Sulfa drugs, etc.)_____
2. Other Medicines _____
3. Any problem with local anesthetics (Novocain, Lidocaine)? Yes ☐ No ☐
4. Latex _____ Betadine (Iodine) _____ Metals (Gold, etc.) _____ Medical Tape _____
5. Have you had problems taking aspirin or Ibuprofen (Advil, Motrin)? Yes ☐ No ☐

LIST ANY SERIOUS ILLNESS WHICH YOU HAVE HAD

1._____	5._____
2._____	6._____
3._____	7._____
4._____	8._____

LIST ALL SURGERIES WHICH YOU HAVE HAD

1._____	5._____
2._____	6._____
3._____	7._____
4._____	8._____

(OVER)

REVIEW OF SYSTEMS

1. CONSTITUTIONAL SYMPTOMS

Good general health lately ..... Yes ❑ No ❑
Recent weight change ..... Yes ❑ No ❑
Fever ..... Yes ❑ No ❑
Fatigue ..... Yes ❑ No ❑

2. EYES

Eye disease or injury ..... Yes ❑ No ❑
Wear glasses/contact lens ..... Yes ❑ No ❑
Blurred or double vision ..... Yes ❑ No ❑
Glaucoma ..... Yes ❑ No ❑

3. EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing ..... Yes ❑ No ❑
Earaches or drainage ..... Yes ❑ No ❑
Chronic sinus problem or rhinitis ..... Yes ❑ No ❑
Nose bleeds ..... Yes ❑ No ❑
Mouth sores ..... Yes ❑ No ❑
Bleeding gums ..... Yes ❑ No ❑
Sore throat or voice change ..... Yes ❑ No ❑
Swollen glands in neck ..... Yes ❑ No ❑

4. CARDIOVASCULAR

Heart trouble ..... Yes ❑ No ❑
Chest pain or angina pectoris ..... Yes ❑ No ❑
Palpitation ..... Yes ❑ No ❑
Shortness of breath with walking or lying flat ..... Yes ❑ No ❑
Swelling of feet, ankles or hands ..... Yes ❑ No ❑

5. RESPIRATORY

Chronic or frequent cough ..... Yes ❑ No ❑
Spitting up blood ..... Yes ❑ No ❑
Shortness of breath ..... Yes ❑ No ❑
Asthma or wheezing ..... Yes ❑ No ❑

6. GASTROINTESTINAL

Loss of appetite ..... Yes ❑ No ❑
Change in bowel movements ..... Yes ❑ No ❑
Nausea or vomiting ..... Yes ❑ No ❑
Frequent diarrhea ..... Yes ❑ No ❑
Painful bowel movement or constipation Yes ❑ No ❑
Rectal bleeding or blood in stool ..... Yes ❑ No ❑
Abdominal pain or heartburn ..... Yes ❑ No ❑
Peptic ulcer (stomach or duodenal) ..... Yes ❑ No ❑

7. PSYCHIATRIC

Memory loss or confusion..... Yes ❑ No ❑
Nervousness ..... Yes ❑ No ❑
Depression ..... Yes ❑ No ❑
Insomnia ..... Yes ❑ No ❑

8. GENITOURINARY

Frequent urination ..... Yes ❑ No ❑
Burning or painful urination ..... Yes ❑ No ❑
Blood in urine ..... Yes ❑ No ❑
Incontinence or dribbling ..... Yes ❑ No ❑
Kidney stones ..... Yes ❑ No ❑

9. MUSCULOSKELETAL

Joint pain ..... Yes ❑ No ❑
Joint stiffness or swelling ..... Yes ❑ No ❑
Weakness of muscles or joints ..... Yes ❑ No ❑
Muscle pain or cramps ..... Yes ❑ No ❑
Back pain ..... Yes ❑ No ❑
Cold extremities ..... Yes ❑ No ❑
Difficulty in walking ..... Yes ❑ No ❑

10. INTEGUMENTARY (Skin, Breast)

Rash or itching ..... Yes ❑ No ❑
Change in skin color ..... Yes ❑ No ❑
Change in hair or nails ..... Yes ❑ No ❑
Varicose veins ..... Yes ❑ No ❑

11. NEUROLOGICAL

Frequent or recurring headaches ..... Yes ❑ No ❑
Light headed or dizzy ..... Yes ❑ No ❑
Convulsions or seizures ..... Yes ❑ No ❑
Numbness or tingling sensations ..... Yes ❑ No ❑
Tremors ..... Yes ❑ No ❑
Paralysis ..... Yes ❑ No ❑
Stroke ..... Yes ❑ No ❑
Head injury ..... Yes ❑ No ❑

12. ENDOCRINE

Glandular or hormone problem ..... Yes ❑ No ❑
Thyroid disease ..... Yes ❑ No ❑
Diabetes ..... Yes ❑ No ❑
Excessive thirst or urination ..... Yes ❑ No ❑
Heat or cold intolerance ..... Yes ❑ No ❑
Skin becoming drier ..... Yes ❑ No ❑

13. HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts ..... Yes ❑ No ❑
Bleeding or bruising tendency ..... Yes ❑ No ❑
Anemia ..... Yes ❑ No ❑
Phlebitis ..... Yes ❑ No ❑
DVT/Blood Clots ..... Yes ❑ No ❑
Past transfusion ..... Yes ❑ No ❑
Enlarged glands ..... Yes ❑ No ❑

14. OTHER

_____

_____

_____

PODIATRIC ASSOCIATES OF NW OHIO, INC.

PRINT NAME_____ **DATE**_____

FAMILY HISTORY:

HAS ANY BLOOD RELATIVE HAD:			IF YES PLEASE INDICATE WHO:
1. Tuberculosis	Yes ❑	No ❑	_____
2. Cancer	Yes ❑	No ❑	_____
3. High blood pressure	Yes ❑	No ❑	_____
4. Heart trouble	Yes ❑	No ❑	_____
5. Diabetes	Yes ❑	No ❑	_____
6. Birth abnormalities	Yes ❑	No ❑	_____
7. Arthritis	Yes ❑	No ❑	_____
8. Stroke	Yes ❑	No ❑	_____
9. Foot problems	Yes ❑	No ❑	_____
10. Mother living	Yes ❑	No ❑	Cause of death _____ Age of death _____
11. Father living	Yes ❑	No ❑	Cause of death _____ Age of death _____
12. Brother living #_____	Yes ❑	No ❑	Cause of death _____ Age of death _____
13. Sister living #_____	Yes ❑	No ❑	Cause of death _____ Age of death _____

PATIENT MEDICAL HISTORY:

1. Stroke ..... Yes ❑ No ❑
2. Heart Attack ..... Yes ❑ No ❑
3. Heart Disease ..... Yes ❑ No ❑
4. High Blood Pressure ..... Yes ❑ No ❑
5. Heart Murmur ..... Yes ❑ No ❑
6. Cardiac Arythmia ..... Yes ❑ No ❑
7. Cholesterol Disease ..... Yes ❑ No ❑
8. Circulation Disease ..... Yes ❑ No ❑
9. Diabetes ..... Yes ❑ No ❑
10. Kidney Disease ..... Yes ❑ No ❑
11. COPD / Emphysema ..... Yes ❑ No ❑
12. Asthma ..... Yes ❑ No ❑
13. Ulcer / GERD ..... Yes ❑ No ❑
14. Bleeding Disorder ..... Yes ❑ No ❑
15. Anemia ..... Yes ❑ No ❑
16. Hepatitis (circle one) A B C ..... Yes ❑ No ❑
17. HIV / AIDS ..... Yes ❑ No ❑
18. Osteoporosis ..... Yes ❑ No ❑
19. Fibromyalgia ..... Yes ❑ No ❑
20. Arthritis ..... Yes ❑ No ❑
    Type _____
21. Gout ..... Yes ❑ No ❑
22. Mental Illness ..... Yes ❑ No ❑
23. Depression ..... Yes ❑ No ❑
24. Thyroid Disease ..... Yes ❑ No ❑
25. Pregnant ..... Yes ❑ No ❑
26. Cancer ..... Yes ❑ No ❑
    Type _____
27. Frequent Infections ..... Yes ❑ No ❑
28. Do you have any artifical joints? ..... Yes ❑ No ❑
    Type: Hip ❑ Knee ❑ Other _____
29. Do you smoke? ..... Yes ❑ No ❑
    #Packs per day _____
    How long been smoking? _____
30. Previously smoked? ..... Yes ❑ No ❑
    #Packs per day _____
    Date quit smoking? _____
31. Recreation drugs? ..... Yes ❑ No ❑
32. Drink alcohol or beer? ..... Yes ❑ No ❑
    light (1-2 per week) ❑ moderate (1-2 per day) ❑
    heavy (more than 2 daily) ❑
33. **EMPLOYMENT** (Check those that apply):
    Sit at job ❑ Stands and walks at job ❑ Retired ❑
    Stand at job ❑ Other ❑
34. **EXERCISE ROUTINE** ..... Yes ❑ No ❑
    Type_____ Frequency _____

(OVER)

Podiatric Associates of Northwest Ohio, Inc. 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 supervisor.

- 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 VISA, MasterCard, Discover, cash or check. **Failure to pay your co-pay at the time of service will result in a $5.00 charge.**

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. 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 co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- 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. 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.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. 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.

- **CHARGES FOR MISSED APPOINTMENTS:** Office visit $25.00 - Surgery/Procedure $50.00**this is not covered by insurance.

Completion of Forms- There is a fee of $20.00 for form completion. This is due from the patient prior to having form completed.
Copy of Medical Records or X-ray- A fee of $10.00 will be charged for a copy of the x-ray. The fee for medical records follows the Ohio law.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ **Date**: _____

_____ Patient initials to indicate copy received.

Revised March 2015