



# Potomac Podiatry Group PLLC

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## PATIENT INFORMATION

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

The best way to contact me is by:  Home phone  Work phone  Cell

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Social Security #: \_\_\_\_\_

Gender:  Female  Male

Marital Status:  Minor  Single  Married  Divorced  
 Separated  Widowed  Engaged

Primary Care Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Primary Language:  English  Spanish  Arabic  
 Chinese  French  Italian  Japanese  
 Portuguese  Russian  Other

Race:  American Indian or Alaskan Native  Asian  
 Black or African American  White  
 Native Hawaiian or Pacific Islander  Other

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Grp # \_\_\_\_\_

Name of Insured \_\_\_\_\_

SSN#: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Gender:  Female  Male

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No

**IF YES, PLEASE COMPLETE THE FOLLOWING:**

Secondary Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Grp # \_\_\_\_\_

Name of Insured \_\_\_\_\_

SSN#: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Gender:  Female  Male

Name of Employer: \_\_\_\_\_

## RESPONSIBLE PARTY

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Name: \_\_\_\_\_

SSN# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

## PHARMACY PREFERENCE

Primary Pharmacy \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## PATIENTS UNDER 18

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Accompanying Adult's Name: \_\_\_\_\_

Who may we thank for referring you?

\_\_\_\_\_

# Financial Policy for Potomac Podiatry Group, PLLC

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- *Payment in full is due at time of service unless prior arrangements have been made.*
- *Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a billing fee of \$6.00 added for the administrative costs of billing.*
- *If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 45 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 45 days, the balance will be due in full from you. If any payment is subsequently made by you insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts in our office.*
- *HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.*
- *Please present your insurance card each time you visit if we participate with your plan to insure proper filing information to submit claims. \*Otherwise your visit may not be covered and you will be responsible for payment.*
- *There is a \$25.00 charge for all returned checks.*
- *Please be on time for your appointment. If you need to reschedule you appointment, we require a minimum of 24 hour notice. If you miss a scheduled appointment without notifying our office a \$50.00 charge will be added to your account.*
- *If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees and/or attorney fees by these services.*

## ASSIGNMENT OF BENEFITS/PRIVACY POLICY

*I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Potomac Podiatry Group, PLLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co- payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I authorize Potomac Podiatry Group to use the Health Information Exchange Network in order to provide more comprehensive medical treatment.*

*By my signature I acknowledge reviewing the financial and privacy policies and hereby agree to their terms.*

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I acknowledge receiving Potomac Podiatry Group's Notice of Privacy Practices (posted in the office and on the website).*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I authorize the following individuals to receive information on my behalf. This includes medical information.*

**Name & Relationship:** \_\_\_\_\_

**Name & Relationship:** \_\_\_\_\_

**Name & Relationship:** \_\_\_\_\_

**REASON FOR VISIT**

What is the chief complaint for which you came to be treated? \_\_\_\_\_

Have you ever been to a Podiatrist before?  Yes  No

If yes, please explain \_\_\_\_\_

Athletic activities which you participate: \_\_\_\_\_

**TOBACCO/SOCIAL HISTORY**

Smoking Status: Are you a Tobacco User?  Yes  No If yes, how many packs per day: \_\_\_\_\_ How many years: \_\_\_\_\_

Current Smoker everyday  Heavy Tobacco Smoker  Light Tobacco Smoker  Former Smoker  Never  Unknown, if ever smoked

Do you drink alcohol?  Yes  No Do you use Drugs?  Yes  No OTHER SOCIAL HISTORY \_\_\_\_\_

**GENERAL MEDICAL HISTORY**

*Place a check mark next to any of the following that pertain to your medical history*

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Allergies/Hay fever	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fracture	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pulmonary Disease
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> TIA/Stroke
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Depression	<input type="checkbox"/> OTHER MEDICAL HISTORY _____	<input type="checkbox"/> HOSPITALIZATIONS _____

**SURGICAL HISTORY**

<input type="checkbox"/> No prior surgical history	<input type="checkbox"/> Endometrial Ablation	<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Mastectomy (Left Right Bilateral)
<input type="checkbox"/> Breast Lumpectomy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Myomectomy
<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Oophorectomy
<input type="checkbox"/> Colectomy	<input type="checkbox"/> Hernia	<input type="checkbox"/> Tonsil/Adenoidectomy
<input type="checkbox"/> Cone Biopsy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> D & C		

**MEDICATIONS**

**(INCLUDE PRESCRIPTIONS, OVER THE COUNTER & VITAMINS)**

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES**

<input type="checkbox"/> No known allergy history	<input type="checkbox"/> Demerol _____ reaction	<input type="checkbox"/> Novocain _____ reaction
<input type="checkbox"/> Adhesive/Tape _____ reaction	<input type="checkbox"/> Iodine _____ reaction	<input type="checkbox"/> Penicillin _____ reaction
<input type="checkbox"/> Anti-coagulant _____ reaction	<input type="checkbox"/> Latex _____ reaction	<input type="checkbox"/> Seafood _____ reaction
<input type="checkbox"/> Aspirin _____ reaction	<input type="checkbox"/> Local Anesthetic _____ reaction	<input type="checkbox"/> Sulfa _____ reaction
<input type="checkbox"/> Codeine _____ reaction		
<input type="checkbox"/> Other _____		

## FAMILY HISTORY

Mother Past Medical History \_\_\_\_\_

Father Past Medical History \_\_\_\_\_

Brother Past Medical History \_\_\_\_\_

Sister Past Medical History \_\_\_\_\_

Is there a Family History of any of these disorders?

Allergies

Diabetes

Heart Attack

Mental Illness

Tuberculosis

Arthritis (any)

Epilepsy

Hypertension

Migraines

Other: \_\_\_\_\_

Cancer

Gout

Kidney Disease

Spinal Disorder

ADDITIONAL CLINICAL NOTES: