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NEW PATIENT INTAKE FORM

PLEASE COMPLETE THIS FORM FOR YOUR FIRST VISIT AND SIGN. NOTIFY US AT FUTURE VISITS IF ANY INFORMATION CHANGES

DATE: _____ REFERRED BY: _____

PATIENT NAME: LAST_____ FIRST _____ M. _____

AGE: _____ SEX: M / F DATE OF BIRTH: _____ SSN: _____

EMAIL ADDRESS: _____

PREFERRED PHONE: _____→ CELL/HOME/WORK
ALTERNATE PHONE: _____→ CELL/HOME/WORK

PRIMARY CARE DOCTOR: _____

CARDIOLOGIST: (IF APPLICABLE) _____

Mailing Address: _____

Marital Status: Single___ Married___ Divorced___ Widowed___ Partner___

Spouse or Significant Other Name: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Occupation: _____

Employer: _____

Employer Address: _____

Re

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ PHONE: _____

ID# _____ GROUP # _____

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS#: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ PHONE: _____

ID# _____ GROUP # _____

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS#: _____ RELATIONSHIP TO PATIENT: _____

PHARMACY NAME: _____ **PHONE #**: _____

TODAY'S COMPLAINT/REASON FOR VISIT: _____

HAVE YOU RECEIVED TREATMENT FOR THIS BEFORE? _____

IF SO, BY WHOM? _____

IS YOUR VISIT RELATED TO:

AN ACCIDENT? _____ AN INJURY? _____ WORKERS COMP? _____

IF ANY OF THE ABOVE, PLEASE DESRIBE HOW, WHEN, WHERE THE ACCIDENT/INJURY OCCURRED:

ARE YOU REPRESENTED BY AN ATTORNEY? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

ACHILLES PAIN FOOT OR ANKLE SWELLING GOUT FLARE UP PERIPHERAL NEUROPATHY

NEUROPATHIC PAIN BURNING PAIN NUMBNESS TINGLING

ANKLE SPRAIN HAMMERTOE TENDONITIS OF FOOT/ANKLE ARTHRITIS BUNION PAIN

DIABETIC FOOT PAIN HEEL PAIN PLANTAR FASCIITIS FLATFEET HIGH ARCHES

ARTERY DISEASE VARICOSE VEINS INGROWN NAIL NAIL FUNGUS

FOOT/LEG WOUND ATHLETE'S FOOT OVERLY SWEATY FEET SKIN RASH

FEVER CHILLS NAUSEA

YOUR MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

ALLERGIES

ANTIBIOTICS: PENICILLIN SULFA KEFLEX
PAIN MEDS: CODEINE MORPHINE ASPIRIN NSAIDS
OTHER: SHELLFISH IODINE ADHESIVE TAPE GENERAL / LOCAL ANES. LATEX METALS/NICKEL
ANY OTHER: _____

YOUR MEDICAL HISTORY: PLEASE CIRCLE OR LIST BELOW

HYPERTENSION CANCER DIABETES HEART ATTACK STROKE
LOW BACK PAIN HERNIATED DISK APPENDECTOMY HERNIA
CORONARY ARTERY DISEASE LIVER DISEASE KIDNEY FAILURE HEADACHES BOWEL DISEASE
BLOOD CLOTS/DVT/PE MENTAL HEALTH ILLNESS COPD MULTIPLE SCLEROSIS PROSTATE
SEIZURES/EPILEPSY TUBERCULOSIS BLEEDING DISORDER SLEEP APNEA
OTHER:

_____

_____

LIST YOUR CURRENT MEDICATIONS: (PRESCRIPTION/PRESCRIBED BY, OVER THE COUNTER, HERBAL REMEDIES)

_____
_____
_____

PRIOR SURGERIES YOU HAVE HAD THAT REQUIRED ANESTHESIA:

_____
_____

DO YOU HAVE:
PACEMAKER SPINAL CORD STIMULATOR DEFIBRILLATOR IMPLANTED PLATES OR SREWS
ARTIFICIAL JOINT: SHOULDER/HIP/KNEE/ANKLE/TOE

ANY SURGICAL OR ANESTHESIA COMPLICATIONS?

_____
_____

SOCIAL HISTORY:

ALCOHOL USE: TYPE _____ NUMBER PER: DAY___ WK ___ MO _____

TOBACCO: #PKS/DAY ___ # YEARS SMOKING _____ IF QUIT, HOW LONG AGO? _____

RECREATIONAL DRUG USE: MARIJUANA COCAINE HEROIN METH

CENTENNIAL FOOT AND ANKLE
PATIENT FINANCIAL RESPONSIBILITY 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 BILLING DEPARTMENT.

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, MEANING THEY ARE DUE ON THE DAY OF SERVICE AT THE TIME OF CHECK IN OR CHECK OUT. WE WILL ACCEPT VISA, MASTERCARD, DISCOVER, CASH OR CHECK.

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 FOR COVERED SERVICES. 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 COPAY/COINSURANCE/DEDUCTIBLE, ALL OF WHICH ARE DUE 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. WE WILL ATTEMPT TO VERIFY BENEFITS FOR SOME SPECIALIZED SERVICES OR REFERRALS; HOWEVER, YOU REMAIN RESPONSIBLE FOR CHARGES TO ANY SERVICE RENDERED. PATIENTS ARE ENCOURAGED TO CONTACT THEIR PLANS FOR CLARIFICATION OF BENEFITS PRIOR TO SERVICES RENDERED.

YOU MUST INFORM THE OFFICE OF ALLINSURANCE 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 PREPAYMENT. 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 $35.00 FOR ALL RETURNED CHECKS. YOUR INSURANCE COMPANY DOES NOT COVER THIS FEE.

24-hour notice is required for cancellation of appointments. Failure to cancel appointments within this timeframe or failure to show for a scheduled appointment will result in a $25.00 charge being added to your account.

A deposit of $500.00 will be required for any inpatient or outpatient surgical procedures that are scheduled on your behalf. This is to ensure that any unmet deductible is covered. This fee is credited back to you if there is any "overpayment" after your insurance company has reimbursed Centennial Foot and Ankle. If you do not show for your surgery, then this fee is forfeited to the practice and another $500.00 deposit will be necessary to reschedule your surgery. Additionally, this deposit will again be forfeited if you don't cancel your surgery within 48 hours of your surgery date.

As is the case with all medical practices, Centennial Foot and Ankle charges for disability, FMLA, and other paperwork that is not covered by your insurance company. You charged for pages that need to be filled out by our doctors, not the total of pages that need to be reviewed. Charges are $60.00 for the first page and $10.00 for each additional page. Handicap/DMV forms are not charged for.

A $15.00 fee is charged for any re-billing of outstanding balances.

Requests for any/all medical records will be charged $.60 per page and $10.00 for a disk or thumbdrive of imaging studies.

A copy of this policy is available in your chart.

By Signing below, you agree to the adhere to the patient financial policy outlined above. This is a requirement to be seen as a patient at Centennial Foot and Ankle.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Date: _____