# NEW PATIENT INFORMATION

## NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_

PARENT OR GUARDIAN (IF MINOR): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_American Indian or

 AGE:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Alaskan Native

 \_\_\_\_\_Asian

 Ethnicity: \_\_\_\_\_Hispanic \_\_\_\_\_Black

 \_\_\_\_\_Non-Hispanic \_\_\_\_\_Caucasian

 \_\_\_\_\_Other

 \_\_\_Male \_\_\_Female \_\_\_Non-Binary \_\_\_\_\_Pacific Islander

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

MARITAL STATUS: Married | Single | Widowed | Divorced

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK OR CELL: \_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER/OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY YOU PRIMARILY USE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### DO YOU TAKE ASPIRIN ON A REGULAR BASIS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE COMPLETE REVERSE SIDE***

***MEDICAL INFORMATION***

PLEASE DESCRIBE THE TYPE OF FOOT PROBLEM YOU ARE HERE FOR:

YOUR PRIMARY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST HOSPITALIZATIONS OR MAJOR SURGERIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESCRIPTIONS / MEDICINES: CHECK IF YOU HAVE CONDITIONS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ DIABETES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ HIGH BLOOD PRESSURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ ASTHMA

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ HIGH CHOLESTEROL

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ HEART MURMUR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ A-FIB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ CORONARY ARTERY DISEASE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ DEPRESSION/ANXIETY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ HYPO/HYPER THYROID

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ STROKE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ OTHER (LIST)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK IF YOU HAVE KNOWN ALLERGIES TO ANY OF THE FOLLOWING:

\_\_\_\_\_PENICILLIN \_\_\_\_\_CODEINE \_\_\_\_\_ASPIRIN

\_\_\_\_\_NOVACAINE \_\_\_\_\_ADHESIVE TAPE \_\_\_\_\_SULFA

IS THERE ANY OTHER MEDICAL CONDITIONS FOR WHICH YOU ARE PRESENTLY RECEIVING TREATMENT?

HEIGHT \_\_\_\_\_\_FT \_\_\_\_\_\_INCHES WEIGHT \_\_\_\_\_\_\_\_ LBS

*THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE:*

 *(SIGN NAME) (TODAY’S DATE)*

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUMBER OF CHILDREN:\_\_\_\_\_\_\_\_

OCCUPATION (circle): full-time part-time homemaker unemployed student retired

NUTRITION (circle): poor average good excellent vegetarian

EXERCISE (circle): none inconsistent active lifestyle

 or regular (specify activity or sport):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_

SMOKING (circle): never a smoker former smoker social smoker

 secondary smoke exposure

 or current smoker (amount):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALCOHOL (circle): none rare occasional currently drinks socially drinks

 How many drinks per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ILLICIT (illegal) DRUGS: yes no

MOTHER (circle): alive & well deceased natural causes deceased

(cause):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER (circle): alive & well deceased natural causes deceased

(cause):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY OF DISEASES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES TO MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, WHAT IS REACTION?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (CIRCLE ONE) Severe moderate mild

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 CHOOSE) AND UNDERSTOOD THE NOTICE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PATIENT NAME (PRINT) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE

MY RECORDS MAY BE RELEASED TO:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

IE: PARENT OR GUARDIAN OR POA (PRINT NAME)

**Patient Financial Responsibility Policy**

Thank you for choosing Mohawk Valley Podiatry for your healthcare needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of their treatment options and the financial obligations for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our staff before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit(s).

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Patients have many different types of insurance and payment options for services rendered. To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card(s).

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service.

***Participating Plans:*** You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit your medical claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

***Non-Covered Services:*** If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier, or a claim can be mailed to you.

***Copayments or Deductibles:*** If your doctor waives your copayment or deductible, he/she is in effect giving you a discount. Therefore, if he/she is willing to provide this service to you at a discount, he/she must disclose this to your insurer and give the same discount to them. **All co-pays, deductibles, and non-covered services will be collected at the time of service.**

***Cancellations and Missed appointments:*** Our Policy is to charge for missed appointments not canceled within 24 hours, or at the discretion of the office manager. These charges will be your responsibility and billed directly to you.

***Late Charges:***  We may assess a late payment charge, which will be applied to all patient balances over 60 days old.

***Returned Checks:***  Will incur a $30 service charge.

***Nonpayment:*** If your account is over 150 days past due, you will need to pay in full unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During those 30 days, we will only be able to treat you on an emergency basis.

***Collection Fees:***  In the event my account is placed in collection status, any fees incurred due to this will be added to my outstanding balance. These charges will be your responsibility and billed directly to you.

***Payment:*** For your convenience, the following payment methods are accepted cash, personal check, Visa, MasterCard, American Express, and Discover.

I authorize payments to be made directly to Mohawk Valley Podiatry and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to Mohawk Valley Podiatry for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

**I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Name of Patient or Responsible Party*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient or Responsible Party*

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_