NORTHEAST FAMILY PODIATRY

• Andrew Hune, DPM • Kirsten Grau, DPM • Stephen Dunham, DPM • Samuel Bell, DPM • Gerald Campo, DPM

261 Delaware Avenue Delmar, NY 12054
4 Atrium Drive, Suite 250 Albany, NY 12205

1971 Western Avenue, Albany, NY 12203
2317 Balltown Road, Suite 102, Niskayuna, NY 12309

Phone: (518) 439-0423 **www.bethlehemfootcare.com** **Fax: (518) 478-9044**

PATIENT DEMOGRAPHIC FORM

Patient Name:_____

Address:_____**City/State:**_____**Zip:**_____

Home Phone: _____ **Mobile:** _____ **Work:** _____

Email: _____

Date Of Birth: _____ **Age:** _____ **Sex**: **M / F** **Primary Language:** _____

Race: (circle) White Black American Indian Asian Native Hawaiian Other Race Declined to Specify Unknown

Ethnicity: (circle) Hispanic/Latino Not Hispanic/Latino Decline to Specify Unknown

Pharmacy (Name/Address)**:** _____

Primary Care Physician (Name/Address)**:** _____

Marital Status: (circle) Single Married Divorced Separated Widowed Partner Other: _____

Emergency Contact: _____ **Phone:** _____

Preferred Method of Contact:(circle) Phone Text Email Give Consent To All

Referral Source:(circle) Radio Newspaper Internet Family/Friend/Physician:(Name)_____

INSURANCE & BILLING INFORMATION

Policyholders Name: _____ Policyholders Date of Birth: _____

Policyholders Employer: _____

Relationship To Patient: (circle) Self Spouse Parent/Guardian

Patient Signature: _____ **Date:** _____
(Patient / Responsible Party)

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PATIENT MEDICAL HISTORY

Patient Name:_____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Shoe Size:** _____

Reason For Visit: (Describe Foot Concerns)_____

Medications(*please list)*: _____

_____

Allergies(*please list)*:_____

Do You Have Any Advanced Directives? ☐ **NO** ☐ **YES:**(Please Specify)_____

Have you fallen in the last year?: ☐ **NO** ☐ **YES**

If yes, did this fall result in an injury?: ☐ **NO** ☐ **YES:** _____

Surgical History:*(Please include date of surgery)* _____

_____

Social History: ☐ **Drinks Alcohol** ☐ **Uses Recreational Drugs**

Smoking Status: ☐ **Never Smoker** ☐ **Former Smoker** ☐ **Current Smoker**

Family History:

Mother:	☐ **Stroke**	☐ **Diabetes**	☐ **Heart disease**	☐ **Cancer**	☐ **Hypertension**	☐ **Anemia**
Father:	☐ **Stroke**	☐ **Diabetes**	☐ **Heart disease**	☐ **Cancer**	☐ **Hypertension**	☐ **Anemia**

MEDICAL HISTORY: Do you have any of the following?					
Diabetes Type 1	Yes	No	**Diabetes Type 2**	Yes	No
If Yes: Last A1C: _____			**If Yes: Last A1C: _____**		
Arthritis	Yes	No	High Cholesterol	Yes	No
Anemia	Yes	No	HIV	Yes	No
Asthma	Yes	No	Phlebitis	Yes	No
Bleeding Problems	Yes	No	Poor Circulation	Yes	No
Broken Bones	Yes	No	Psoriasis/Eczema	Yes	No
Cancer	Yes	No	Rheumatic Disease	Yes	No
Type: _____			Skin Ulcers	Yes	No
Emotional Problems	Yes	No	Stomach Problems	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Heart Problems	Yes	No	Thyroid Problems	Yes	No
Kidney Problems	Yes	No	Venereal Disease	Yes	No
Hepatitis	Yes	No	Venous Insufficiency	Yes	No
High Blood Pressure	Yes	No	Other: _____		

Patient Signature:_____ **Date:** _____

(Patient / Responsible Party)

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PATIENT MEDICAL HISTORY (continued)

Review of Systems – Have you recently had any of the following?: (please circle yes or no below)

GENERAL:		
Fever	Yes	No
Chills	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No
NEUROLOGIC:		
Seizure	Yes	No
Migraines	Yes	No
Dizziness	Yes	No
Foot & Ankle Numbness	Yes	No
SKIN:		
Lumps	Yes	No
Rashes	Yes	No
Lesions	Yes	No
Itchiness	Yes	No
PULMONARY:		
Shortness of Breath	Yes	No
Cough	Yes	No
History of TB/+PPD	Yes	No
GENITOURINARY:		
Blood in Urine	Yes	No
Pain with Urination	Yes	No
Nighttime Urination	Yes	No
Recent UTI	Yes	No
Frequent Urination	Yes	No
Urine Retention	Yes	No

CARDIOVASCULAR:		
Chest Pain	Yes	No
Palpitations	Yes	No
Shortness of Breath on Exertion	Yes	No
Heart Attack	Yes	No
Stroke	Yes	No
BLOOD:		
Anemia	Yes	No
Bleeding	Yes	No
Bruising	Yes	No
Blood Clots	Yes	No
Transfusions	Yes	No
GASTROINTESTINAL:		
Abdominal Pain	Yes	No
Heart Burn	Yes	No
Indigestion	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Food Intolerance	Yes	No
Pain with Swallowing	Yes	No
PSYCHIATRIC:		
Anxiety	Yes	No
Depression	Yes	No
Memory Loss	Yes	No
MUSCULOSKELETAL:		
Joint Pain	Yes	No
Joint Swelling	Yes	No
Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No

Patient Signature:_____ **Date:** _____
(Patient / Responsible Party)

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Office and Financial Policies and Advanced Beneficiary Notice

Welcome and thank you for choosing Northeast Family Podiatry for your medical care. We are committed to providing you with the highest quality medical care in an efficient, timely and cost-effective manner. We hope that by providing you with our office policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____ I hereby by give permission to the podiatrist and any assistants to administer treatment and to perform such procedures as may be deemed necessary in the treatment of my foot and/or ankle disorder.

Initials:_____ Notice of Privacy Practices, HIPPA and PHI, I have received, read, and understand that I have certain rights to privacy in regards to my protected health information (PHI). I am aware that a copy of my rights are always available to me.

Initials:_____ Patient Portal: I hereby by give consent to electronic communications through the patient portal.

Initials:_____ Insurance: The patient is responsible for knowing their insurance benefits and whether you have a copay and/or deductible. We will gladly submit your insurance claim. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefits. We do not accept third party insurance. We do not accept any type of Medicaid plan.

Initials:_____ Self-Pay: Any patient who (1) does not have health insurance coverage, (2) is covered by an insurance plan which we do not participate in, (3) does not have valid insurance or an insurance card on file (4) provides the incorrect insurance information is considered a Self-pay account and expected at time of visit.

Initials:_____ Reporting Non-Compliance: It is our responsibility to report patients who: fail or refuse to pay copayments/deductibles at the time of service, or who repeatedly fail to show for appointments.

Initials:_____ Cancellations/No Show/Late Arrivals: We require 24 hour advanced notice if you are unable to keep your scheduled appointment. If you do not call in the allowed time frame it will result in a $25.00 charge. Failure to show for an appointment will also result in a $25.00 charge. Should you miss more than two appointments in a row, you may not be allowed to reschedule. We do our best to keep on schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment so other patients are not inconvenienced.

Initials:_____ Dishonored checks: A $35 service fee will be assessed on all returned checks. The full amount of the check written plus $35.00 must be paid by cash or credit card.

Initials:_____ Billing/Payments/Refunds/Collections: All balances are expected to be paid within 14 days of statement date. Repeat billing will have an additional charge of $10.00. It is your responsibility to inform our office of any changes in address, phone or insurance. Should any balance not be satisfied within 90 days, we reserve the right to report delinquent accounts to credit bureaus and your account will be turned over to collections, charged an additional 33.3% fee of your balance owed, and subject to any additional fees from the collection agency, and we may terminate you as a patient of the practice. Should you make an overpayment, we will refund only if there is no other outstanding debt on your or family account. We may opt to place as a credit on your account if you frequent the office.

Initials:_____ Surgery: Our surgical financial policy will be discussed prior to the procedure(s). If minor surgery is performed at the initial visit (ie: nail or wart removal), payment is due at the time of visit.

Initials:_____ Orthotics: Orthotic devices are sometimes prescribed as a part of your treatment plan. The fee for orthotics will be reviewed and payment is due prior to the fabrication of orthotics.

Initials:_____ ADVANCED BENFICIARY NOTICE: All fees for services rendered are the responsibility of the patient: for those carriers with who we do not contract; for any services not covered or deemed not medically necessary by your carrier; or in the case where the patient has failed to provide us with updated and accurate insurance information.

I authorize the use of this form and release of information for all of my insurance submission. I authorize payment directly to my doctor. I also understand I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers. I have read, understand and agree to the provisions of the *Advanced Beneficiary Notice, Financial Policy and Signature on File.* I also permit a copy of this authorization to be used in place of the original.

Print Patient Name

Signature of Patient/Responsible Party **Date**