PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient Name/Nombre _____Birthdate/Fecha de Nacimiento _____

Address/Direccion_____City/Ciudad_____State/Estado____Zip/Codigo_____

Email_____ Phone number(s)/ Numeros _____

Sex ◯**Male** ◯**Female** Age/Edad____ Marital Status:__M__S__W__D HEIGHT:_____ WEIGHT:____ SHOE SIZE:_____

Employer/Empliado_____Occupation/Ocupacion_____**SS#**_____
Whom may we thank for referring you? A quien podemos agradecer por referirlo?_____

INSURANCE/SEGUROS Who is responsible for this account? Quien es responsable de esta cuenta?_____

GUARANTOR/GARANTE_____Birthdate/Fecha de Nacimiento_____

Relationship to patient/Relacion al paciente ___Self/Mismo ___Spouse/Esposo(a) ___Child/Nino(a) ___Parent/Padres

PRIMARY INSURANCE/SEGURO PRIMARIA _____**SECONDARY INSURANCE/SEGURO SECUNDARIA**_____

*Briefly describe your foot problem/Describe brevemente su problema en el pie*_____

*Date of onset/fecha de inicio*_____

GENERAL MEDICAL HISTORY/HISTORIA MEDICA GENERAL *(please check if you have ever had any of the following/por favor, compruebe si ha tenido alguna vez cualquiera de las siguentes)*

◊**anemia** ◊arthritis/artritis ◊asthma/asma ◊blood disorder/trastornos de la sangre ◊bronchitis/bronqutis ◊**cancer** ◊circulation problems/problema de circulacion ◊ **diabetes** ◊ear/eye trouble/problema de los oidos/ojos ◊elevated cholesterol/colesterol elevado ◊gout/gota ◊heart trouble/problemas del Corazon ◊high blood pressure/alta presion ◊HIV/VIH ◊intestinal problems/problema intestinal ◊kidney disease/enfermedad renal ◊liver disease/enefermedad hepatica ◊phlebitis/flebitis ◊prolonged bleeding/sangrado prolongado ◊rheumatic fever/fiebre reumatica ◊stroke ◊seizure disorder/trastornos convulsivos ◊stomach ulcers/ulceras estomacales ◊**tuberculosis** ◊other/otros_____

Do you have a family history (siblings/parents/grandparents) of : ◯DIABETES ◯HEART DISEASE ◯FOOT PROBLEMS

PHARMACY NAME/PHONE/ADDRESS (NOMBRE/NUMERO/DIRECCION DE FARMACIA)_____

ALLERGIES/ALERGIAS □ no known drug allergies/sin alergias medicamentosas conocidas □ codeine □local anesthetic/anastesico local □ penicillin/penicilina □ others/otros _____

CURRENT MEDICATIONS/MEDICAMENTOS ACTUALES_____

_____

OPERATIONS/OPERACIONS*HOSPITALIZATIONS/HOSPITALACIONES_____

_____

Do you use: Tobacco/usa Tabaco? □yes □no Alcohol: □socially □regularly □NO other substances/otras sustancias: □yes □no

I hereby give Jose F. Hilario DPM permission to examine and treat my feet. I also assign to Jose F. Hilario DPM P.A. all payment for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by my insurance. I also authorize release of medical information necessary to process any health insurance claims. A copy of my signature on file will be considered as valid as the original. 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 choose) and understand the notice.

Signature_____ Date_____

OFFICE POLICIES/FINANCIAL POLICIES

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship.

Please ask if you have any questions about our fees, financial policy, or your responsibility.

All patients must sign our Financial Policy prior to receiving their first treatment.

*********PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTOOD THE FOLLOWING:********

(Not all policies will pertain to you)

____ 1. PAYMENTS: All applicable fees, deductibles, coinsurance, or copays must be paid at the time of the appointment. We accept cash, Visa, MasterCard and Discover.

____ 2.MISSED APPOINTMENTS/CANCELLATIONS- If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. $40 will be charged for missed appointments. We understand on occasions unavoidable delays will prevent you from arriving on time, we urge that you give us a courtesy call to inform us If you are running late or having an emergency.

____ 3.FMLA/ DISABILITY- There is a $50.00 charge for each FMLA/Disability claim form. We require at least two weeks for processing, and payment is due before form(s) are completed. If forms are needed sooner the fee is $75. Any long term disability forms will be $100 charge.

____ 4.MEDICAL RECORDS- There is a $25.00 fee for medical records up to the first 20 pages; each additional page is .50 per sheet. *WE REQUIRE AT LEAST TWO WEEKS NOTICE. PAYMENT IS DUE BEFORE PROCESSING.*

____ 5.COLLECTIONS- In rare cases, when we are unable to collect any outstanding balances in our office, we may, at our discretion use an outside collection agency/credit reporting service. A $50.00 service fee will be added to your account if we have to utilize any outside agency.

____ 6.HMO/REFERRALS/AUTHORIZATIONS- If your insurance requires a authorization from your primary care physician (PCP) We will request the authorization ahead of time for established patients only. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. It is ultimately your responsibility to make sure your visit is pre-approved, or you will be responsible for payment in full.

____7.MEDICATION REFILLS- Depending on medication needing to be refilled we may ask you to schedule an appointment. If any refills are needed you must contact your pharmacy to send refill request. If it has been more than 30 days that you have been seen we require you to make an appointment.

____ 8.CELL PHONES-Cell phones must not be used once you are in the exam room.

Our exam rooms have limited space and we ask that only one family member accompany the patient if necessary.

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 chose***) and understood the Notices.

_____	_____	_____
Patient Name (**please print**)	Signature of patient/guardian	Date