

CHART # _____

Patient Information

Patient Name:

Last name

First name

M.I.

Desired name:

Date of Birth: / /

Age:

Social Security Number: - -

Email address:

Mailing address:

Street/P.O. Box

City

State

Zip code

Email Address (if we can we email you newsletters and appointment reminders): _____

Home Phone:

Cell Phone:

Best Contact #:

Emergency Contact Person:

Phone #:

Gender: Male Female Marital Status: Single Married Widowed Separated Divorced

Who do you authorize us to release/discuss your medical information to? Name: _____

Primary Care Physician:

Date of last visit: / /

How did you hear about us? WEB PCP (name: _____) FRIEND (name: _____) INSURANCE

****PLEASE TELL US WHO REFERRED YOU TO OUR PRACTICE SO WE CAN THANK THEM.****

Employer:

Position:

Phone:

Preferred Pharmacy:

Insurance Information

Name of Insured (if not patient);

Relationship to Patient:

Employer:

Date of Birth:

Occupation:

Social Security Number:

Work Phone:

Workers Compensation Case

Claim #:

Case Manager:

Phone:

Workplace Contact Name:

Position/Title:

Phone:

Date last worked:

Are you working now?

Insurance & Payment Policy

It can be very difficult for the average person to understand their insurance plan. Also, many insurance plans are changing. Unfortunately, there are hundreds of different insurance plans and almost all of them have their own rules. There is little consistency from company to company or even among different plans offered by the same company. The need for referrals, deductibles, copays, prior authorization, in network, out of network differs from insurance plan to insurance plan. It is in your best interest to find out your coverage before you arrive at the office for your appointment. No one likes to be surprised by their bill after being seen.

In 2016, **INSURANCE/MEDICARE DOES NOT COVER TRIMMING OF NAILS, CORNS, AND CALLUSES.** Please ask your insurance company if your are covered. You will have to pay for the service at the time of the visit.

****Patients are financially responsible for all charges to their account****

****Patients are responsible for insurance referrals****

****CREDIT CARDS-** If you use a credit/debit card, we may have to pass on a processing fee determined by your bank. Thank you!

Patient Name:

Authorization for treatment, assignment, and Release:

I hereby give the Global Podiatry Partners, Inc (Drs. Chugo Rinoie and Wenjay Sung) and its staff members permission to treat my feet and/or ankle disorders. I, the undersigned, have **insurance** coverage with _____ and assign directly to Global Podiatry Partners, Inc (Drs. Chugo Rinoie and Wenjay Sung) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of insured/guardian:

X **Date:** / /

MEDICARE/ INSURANCE Authorization:

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to Global Podiatry Partners, Inc (Drs. Chugo Rinoie and Wenjay Sung) for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured, Guardian, or Beneficiary:

X **Date:** / /

Notice of Privacy Practices – Acknowledgement of Receipt:

I hereby acknowledge I have received a copy of Notice of Privacy Practices and I have read and understand the notice that is posted in the reception area, and a copy will be made available to me upon request.

Signature of insured/Guardian:

X **Date:** / /

Medical History

Chief Concern/Present Illness:

What is your present foot problem?

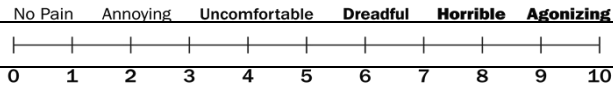
If due to injury, give date and details:

How long have you been bothered by the above?

What have you done for your foot problem? Padding NSAID's Altered shoe wear X-rays
 Soaks Altered Activity Physical Therapy Injections Shoe Inserts Surgery
 Topical Medications

Have you had previous foot care/surgery? If so, by whom?

On a scale of 0-10, what is your pain level?



Medical History:

Are you now or have you ever been under a physician's care during the past two years? YES No

Date of last complete physical exam: / /

Are you allergic to any medications? * (Circle all that apply) *****

No Known Drug Allergies	Adhesive Tape	Amoxicillin	Aspirin	Augmentin
Betadine	Codeine	Demerol	Erythromycin	Ibuprofen
Iodine	Keflex	Latex	Morphine	NSAIDs
Penicillin	Sulfa Drugs	Tylenol	Novocaine	Antihistamines
Other (list to the right):				

Medications: Are you presently taking any medications? Yes No

List medications below:

Past Medical History: (Circle if you now have or were ever treated for)

AIDS/ARC	Circulation Disorders	High Blood Pressure	Rheumatic Fever
Allergies	Diabetes (insulin or non-insulin dependent)	Kidney Disease	Stomach Ulcer
Anemia	Epilepsy	Leg Cramps	Stroke
Anesthesia Problems	Glaucoma	Liver Trouble	Tuberculosis
Arthritis	Gout	Mental Health Conditions	Ulcers
Asthma	Heart Disease-Type ()	Mitral Valve Prolapse	Venereal Disease
Bleeding Tendency	Heart Murmur	Polio	
Cancer - Type ()	Hepatitis-Type ()	Previous Foot Condition	

Medical History cont.

Have you ever had surgery? YES NO

List type of Surgery below	<u>Year</u>	<u>Year</u>
1.	5.	
2.	6.	
3.	7.	
4.	8.	

Family History: (Circle if any blood relatives have had)

Arthritis	Cancer	Diabetes	Heart Disease
High Blood Pressure	Kidney Disease	Overweight	Other: (list below)

Foot problems similar to yours? Mother Father Siblings

Social History:

Use of Alcohol: Never Rarely Moderate Daily
 Use of Tobacco: Never Previously but quit (date:) Current packs/day
 Use of Drugs: Never Type/Frequency ()

Review of Systems: (Please indicate current health status below by circling existing conditions)

Constitutional Symptoms	Gastrointestinal	Integumentary (skin)	Psychiatric
Good general Health lately	Loss of Appetite	Rash or itching	Blurred or double vision
Recent weight change	Nausea or vomiting	Change in skin color	Memory loss or confusion
Fever	Frequent diarrhea	Change in hair or nails	Depression
Fatigue	Genitourinary	Varicose veins	Insomnia
Eyes	Kidney Disease	Dry skin	Endocrine
Eye disease or injury	Dialysis	Neurological	Diabetes
Wear glasses/contact lenses	Kidney Stones	Frequent or recurring headaches	Glandular or hormone problem
Cardiovascular	Musculoskeletal	Light headed or dizzy	Excessive thirst or urination
Chest pain or angina pectoris	Joint pain	Convulsions or seizures	Heat or cold intolerance
Shortness of breath	Joint Stiffness or swelling	Numbness or tingling sensations	Hematologic/Lymphatic
Swelling of feet, ankles or hands	Weakness in muscles or joints	Tremors	Slow to heal after cuts
Respiratory	Muscle pain or cramps	Paralysis	Bleeding or bruising tendency
Chronic or Frequent coughs	Back pain	Head injury	Anemia
Spitting up blood	Cold Extremities	Stroke	Phlebitis
Shortness of breath	Difficulty in walking		Past transfusion
Wheezing	Neuromuscular disease		

Shoe Size: ()

-----Office use only below-----

I have reviewed with the patient the complete history provided: **X** / /

Wenjay Sung, DPM, FACFAS

Date

Thank you for your cooperation!