DR. MAASI J. SMITH
FOOT CARE

25 Bala Ave Bala Cynwyd PA 215-665-9225, Fax 215-665-9242

NEW PATIENT FORM

NAME: _____ **DATE OF BIRTH:** ____/____/____ **AGE:** _____

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Home #** _____ **Cell #** _____ **Work #** _____

Email _____ **Preferred Method of communication?** Home # / Cell # / Email

Gender Male / Female **Marital Status** Single / Married / Divorced / Widowed **Ethnicity** Non-Hispanic / Hispanic / Decline to specify

Race American Indian/ White/ Asian/ African American/ Native Hawaiian/ Decline to specify **Occupation** _____

Preferred Language _____ **Who referred you?** Internet/Insurance Co./YellowPages/Friend/Dr. _____

Emergency Contact _____ **Relationship** _____ **Phone#** _____

Person (other than yourself) whom we may share your personal health information:

Name _____ **Relationship** _____ **Phone#** _____

Primary Care Physician _____ **City** _____ **Last Visit** _____

PHARMACY _____ **Pharmacy #** _____

Pharmacy Address _____

INSURANCE INFORMATION

Insurance #1 _____ **Insurance #2** _____

If you don't have insurance, how will you be paying? Cash / Check / Credit Card

PARTY RESPONSIBLE FOR BILL (If different from patient)

Relationship to Patient _____ Name _____

Address _____ Phone# _____

Employer _____ Phone# _____

ACKNOWLEDGMENT

- I certify the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and or ankles.
- I authorize the release of any medical information necessary to process claims. I further authorize payment of medical benefits directly to the physician for services rendered.
- Notice of Privacy Practices: I have read (or had the opportunity to read) and understand the HIPAA privacy and compliance practices maintained by Premier Podiatry-East Cobb.

SIGNATURE of Patient / Responsible Party _____

PRINTED name of patient / Responsible Party _____ **Date** _____/_____/20____

Premier Podiatry-East Cobb
PATIENT FINANCIAL 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.

- _____ *(Initial)* **All applicable co-pays, deductibles and co-insurance and/or non-covered services are due at time of service. These amounts are estimates given to us by your insurance company based on our contract with them. Once the claims have been adjudicated by your ins. company, there is a possibility that you may end up receiving a balance statement or a refund check.**
- _____ *(Initial)* 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 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.***
- _____ *(Initial)* 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. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- _____ *(Initial)* Your insurance company may request information from you before processing a claim, and it is your responsibility to comply with their request. Failure to comply may result in denial of your claim, and you will be responsible for all charges incurred.
- _____ *(Initial)* As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- _____ *(Initial)* You must inform the office of all-insurance changes and authorizations/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- _____ *(Initial)* **There are NO refunds for supplies purchased in the office.** Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome.
- _____ *(Initial)* For Workers Compensation patients: we require a verified authorization from your insurance carrier prior to your initial visit. If your claim is denied you are responsible for payment in full.
- _____ *(Initial)* 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. **A 25% increase will be added to all patient accounts that are moved to a collection status.**
- _____*(Initial)* There is a service fee of $25.00 for all returned checks.

Signature of Patient/Responsible Party: _____ Date: ____/____/____

Printed Name of Patient/Responsible Party: _____

Referred by:_____ Today's Date:____/____/____

BP____/____

PR____

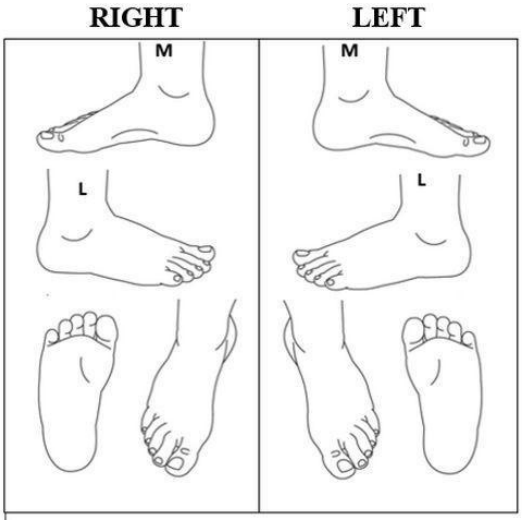
DR. MAASI J. SMITH
FOOT CARE
5201 Wynnefield Ave Philadelphia PA 215-665-9225

NAME: _____ **DATE OF BIRTH:** / / **AGE:**

REASON FOR TODAY'S VISIT *(circle what applies)*

Heel Pain	Plantar Fasciitis	Ingrown Toenail
Warts	Neuroma *(Pinched nerve)*	Fractures
Nail Fungus	Athlete's foot	Bunion
Hammertoes	Callus	Ankle Pain

Other : _____



Pain Type: Aching / Throbbing / Shooting / Sharp / Stabbing

Pain Score: _____(**0**-*No pain*; **10**- *The worst pain you have ever felt*)

When did this problem begin? _____

What types of treatment have you tried? _____

What is your: Height _____ **Weight**_____ **Shoe Size**_____

MEDICAL HISTORY *(Past and/or Current-Check to those that apply)*

◯	Anemia	◯	Depression	◯	Hyperthyroidism	◯	Sickle Cell Disease
◯	Acid Reflux	◯	Drug Abuse	◯	Kidney Disease	◯	Seizures
◯	ADHD	◯	Epilepsy	◯	Liver Disease	◯	Varicose Veins
◯	Alcohol Abuse	◯	Fibromyalgia	◯	Lupus	◯	Blood Clots - year: _____
◯	Anxiety	◯	Glaucoma	◯	Migraines	◯	Heart Problems - Specify:_____
◯	Asthma	◯	Gout	◯	Osteoarthritis	◯	Stroke - year_____
◯	Auto Immune Disease	◯	High Blood Pressure	◯	Osteoporosis	◯	Cancer - Type:_____Year:_____
◯	Blood Disorders	◯	High Cholesterol	◯	Psoriasis		
◯	Cataracts	◯	Hepatitis A, B, C	◯	Peripheral Vascular Disease	◯	Diabetes - Circle: Type I or II - for_____yrs?
◯	Charcot Joint	◯	HIV/AIDS	◯	Rheumatoid Arthritis	◯	Neuropathy
◯	Cramps-Leg/foot	◯	Hypothyroidism	◯	Stomach Ulcers		

Other:_____

IF DIABETIC

Doctor that manages your diabetes? _____ ***City*** _____ ***Phone#*** _____

EXACT date last seen *(mm/dd/yy)*_____/_____/_____ ***Blood Glucose this Morning***_____

Last Hemoglobin A1C _____ ***Last Eye exam*** *(mm/dd/yy)* _____/_____/_____

SURGICAL HISTORY *(Check those that apply)*

		Year			Year			Year			Year
◯	Angioplasty		◯	Carotid Artery		◯	Hernia repair		◯	Vein Ligation	
◯	Appendectomy		◯	Cataract		◯	Kidney surgery		◯	Foot surgery	
◯	Ankle surgery		◯	D & C		◯	Mastectomy		◯	Metal in Body	
◯	Arterial By-pass		◯	Gallbladder Surg		◯	Heart surgery		◯	Pacemaker	
◯	Back surgery		◯	Hysterectomy		◯	Prostate surgery		◯		
◯	Breast Biopsy		◯	Hip surgery		◯	Tonsillectomy		◯		
◯	C-section		◯	Knee Surgery		◯	Stents (heart/legs)		◯		

Other:_____

ALLERGIES *(Check those that apply)*

◯	**No Known Drug Allergies**

		Reaction
◯	Aspirin	
◯	Anesthetics	
◯	Adhesive/Tape	
◯	Codeine	

		Reaction
◯	Cortisone	
◯	Iodine/Betadine	
◯	Latex	
◯	Penicillin	

		Reaction
◯	Sulfa	
◯	Shellfish	

Other:_____

FAMILY HISTORY *(Circle if it applies)*

Mother	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:
Father	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:
Siblings	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:

SOCIAL HISTORY *(Check those that apply and explain)*

	No	**Yes**		
Do you drink alcohol?			*If yes, how much?*	
Any illicit drug use?			*If yes, explain*	
Do you smoke?			*If yes, how much?*	
Did you ever smoke?			*If yes, for how long?*	*If yes, when did you quit?*
Are you pregnant?			*If yes, how far are you?*	

ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING? *(Circle what applies):*

GENERAL	Fever	Chills	Diarrhea	Nausea/Vomiting
HEAD & EYE	Dizziness	Headaches	Double vision	Fainting
EAR/NOSE/THROAT	Hearing Loss	Sinus problems	Tinnitus	Hoarseness
RESPIRATORY	Asthma	Bronchitis	Shortness of breath	Emphysema
GASTROINTESTINAL	Heartburn	Diarrhea	Vomiting	Ulcers
URINARY	Incontinence	Blood in urine	Painful urination	Frequent urination
MUSCULOSKELETAL	Muscle aches	Weakness	Swollen joints	Back pain
SKIN	Rash	Itching	Dryness	Sores
NEUROLOGICAL	Numbness	Tics	Paralysis	Tremors
ENDOCRINE	Excessive hunger	Excessive Sweating	Excessive thirst	

MEDICATIONS

Name of Medication	**Dosage (mg)**	**How many times per day?**

I ACKNOWLEDGE THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TRUTHFULLY & COMPLETELY TO THE BEST OF MY KNOWLEDGE & RECOLLECTION.

SIGNATURE _____ DATE _____/_____/____