NORTHWEST PODIATRY CENTER

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WELCOME: Thank you for choosing Northwest Podiatry Center for your foot care needs. Below are questions to help us get better acquainted and provide information vital to your health. Please feel free to discuss matters of a private nature with the doctor. This information will be kept confidential.

PATIENT INFORMATION

NAME: (LAST)_____ (FIRST)_____ (M.I.)_____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____-_____

HOME PHONE#:_____ WORK PHONE#:_____ CELL PHONE#:_____

MAY WE E-MAIL INFORMATION TO YOU? □ NO □ YES EMAIL ADDRESS_____

MAY WE TEXT INFORMATION TO YOU? □ NO □ YES

BIRTH DATE:_____ AGE:_____ SOCIAL SECURITY#:_____ □ MALE □ FEMALE

EMPLOYER:_____ EMPLOYER ADDRESS:_____ OCCUPATION:_____

Race:_____Ethnicity:_____ HT:_____ WEIGHT:_____SHOE SIZE:_____

□ SINGLE □ MARRIED □ WIDOWED □ SEPARATED □ DIVORCED

Is there a family member or other person you would like us to release medical information to: _____

RELATIONSHIP TO PATIENT:_____ PHONE# (_____)_____

IF PATIENT IS A MINOR (under 18)

FATHER NAME: Last_____First_____M.I. _____ MOTHER NAME: Last_____First_____M.I____

ADDRESS:_____ ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE#_____ CELL PHONE#_____ HOME PHONE#_____ CELL PHONE#_____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? □ YES □ NO CLAIM# _____ ADJUSTER INFORMATION_____

YOUR PRIMARY INSURANCE CO.:_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

CO-PAY: □ YES □ NO AMOUNT OF CO-PAY: $_____

DO YOU HAVE SECONDARY INSURANCE? □ YES □ NO

NAME OF SECONDARY INSURANCE COMPANY:_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

OFFICE VISIT INFORMATION

WHAT BRINGS YOU TO THE OFFICE TODAY _____

HOW LONG HAS IT BOTHERED YOU? □ DAYS □ WEEKS □ MONTHS □ YEARS

ANY PAST PROBLEMS WITH YOUR FEET OR ANKLES? □ YES □ NO PLEASE DESCRIBE_____

HOW WERE REFERRED TO OUR OFFICE? _____

□ YELLOW PAGES □ INSURANCE DIRECTORY □ INTERNET AD □ FRIEND □ PATIENT □ DOCTOR □ RELATIVE

****PLEASE COMPLETE *ALL* INFORMATION ON *BOTH* SIDES OF FORM *****

MEDICAL INFORMATION

WOULD YOU LIKE YOUR PODIATRIC REPORT SENT TO YOUR MEDICAL DOCTOR? □ YES □ NO

FAMILY DOCTOR NAME:_____ LAST VISIT:_____

ADDRESS:_____ PHONE# (_____)_____FAX#(_____)_____

PHARMACY
NAME_____Phone_____Fax_____

PHARMACY
ADDRESS_____

ARE YOU TAKING ANY MEDICATIONS? □ YES □ NO PLEASE PROVIDE LIST OR FILL IN BELOW

NAME OF MEDICATION	DOSAGE

ARE YOU ALLERGIC TO: □ ASPIRIN □ BETADINE (IODINE) □ CODEINE □ IBUPROFEN □ PENICILLIN □ SULFA □ TAPE OR BAND-AID □TYLENOL
□ OTHER:_____ □ **NO KNOWN DRUG ALLERGIES**

DO YOU HAVE OR HAVE YOU HAD A PROBLEM WITH ANY OF THE FOLLOWING? □ **NONE**

□ Angina	□ Anemia	□ Asthma	□ Back Problems	□ Bronchitis
□ Cancer	□ Cardiac Disease	□ Chronic Renal Disease	□ Cirrhosis	□ Coma
□ Congestive Heart Failure	□ Convulsion / Seizures	□ COPD	□ Diabetes/ High Sugar	□ Emphysema
□ Heart Murmur	□ Heart Attack	□ Hiatal Hernia	□ HIV / AIDS	□Hypercholesterolemia
□ Hyperlipidemia	□ Hypertension	□ Irregular Heartbeat	□ Kidney Disease	□ M.I.
□ Obesity	□ Osteoarthritis	□ Osteoporosis	□ Peripheral Vascular Disease	□ Pneumonia
□ Palpitations	□ Polio	□ Recent Cold	□ Rheumatic Fever	□ Rheumatoid Arthritis
□ Stroke	□ Sleep Apnea	□ Thyroid Disease	□ Tuberculosis	□ Liver Disease
□ Jaundice	□ GERD	□ Fibromyalgia	□ Blood Clot	□ Other

HAVE YOU HAD ANY SURGICAL PROCEDURES OTHER THAN FOOT OR ANKLE? □ YES □ NO
IF YES PLEASE DESCRIBE:_____

DO YOU HAVE ANY ARTIFICIAL JOINTS? □ YES □ NO

DO YOU HAVE A HEART VALVE IMPLANT? □ YES □ NO

SOCIAL HISTORY:

DO YOU SMOKE? □ 1/2 PACK PER DAY □ 1 PACK PER DAY □ 1 1/2 PACKS PER DAY + □ NEVER SMOKED

ARE YOU A FORMER SMOKER □ NO □ YES IF YES WHEN DID YOU QUIT SMOKING?_____

DO YOU USE RECREATIONAL DRUGS □ NO □ YES

DO YOU DRINK? □ NO □ SOCIALLY □ 1 DRINK PER DAY □ 2 DRINKS PER DAY+

FAMILY HISTORY:
MOTHER _____
FATHER _____
BROTHER _____
SISTER _____

IS THERE A FAMILY HISTORY OF BLOOD CLOTS? □ YES □ NO

PATIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **RELATIONSHIP:** □ **MOTHER** □ **FATHER** □ **OTHER**

Northwest Podiatry Center
Review of Systems
(Circle YES or NO)

Patient Name:_____ **Date:**_____

Fevers, chills, or recent weight gain or loss

Yes No

Vision changes

Yes No

Ears, nose, mouth, or throat

Yes No

Chest pain, fast heart rate

Yes No

Shortness of breath, persistent coughing

Yes No

Stomach upset, diarrhea, constipation

Yes No

Painful urination, increased or decreased frequency

Yes No

Skin rashes, lesions, or easy bruising

Yes No

Pins and needles sensation in hands or feet, tremors

Yes No

Depression, mood swings, sleep disturbance

Yes No

Swollen hands or feet, blood in urine or stool

Yes No

Frequent sneezing, watery eyes

Yes No

Patient Insurance Responsibility:

To Our Patients:

Due to the number of insurance companies Northwest Podiatry Center participates with, it is not possible to know all the covered benefits your plan offers.

Please familiarize yourself with your insurance plan coverage, (physicians services, test, physical therapy, surgery, medical supplies, orthotics, co-pays, deductibles, co insurance, prior authorization, referrals, etc...) by reading all the information given you buy your insurance company with your enrollment form. Please call the telephone number listed on your insurance card prior to your appointment or services rendered at our office or surgical facility to verify in network /out of net work benefits

Northwest Podiatry Center assumes no liability for any in network / out of network benefit information misquoted by your insurance carrier, or later deemed to be inaccurate. **Patients are responsible for the amounts owed based on their insurance contract with their insurance carrier.**

It is ultimately the patient's responsibility to know their health plan coverage and limitations. Patients will be responsible for non -covered services rendered at our office or surgical facility.

Co-payments are to be paid at the time of each office visit.
*Northwest Podiatry Center accepts cash, checks and credit/debit cards.
(Visa, Master Card, Discover)

Fees are charged for returned checks or insufficient funds.
35% of balance owed applied to accounts placed for collection.

**Monthly statements will be sent to patients until all services are paid in full. **

In order for our office to correctly submit a claim to your insurance company, please notify our office of any changes regarding insurance coverage, home/work address, home/work and cell phone numbers as soon as possible.

In order to keep patient records current all patients are required to complete an update history form on a yearly basis.

We appreciate your cooperation.

Sincerely:

Northwest Podiatry Center

_____ _____

Patient/Guardian Signature Date

Northwest Podiatry Center

Patient registration form

Please read carefully, and **initial** each blank

_____**Privacy Notice (HIPAA)**
I acknowledge I have been provided a copy of the Notice of Privacy Practices, I have read, or have had the opportunity to read, and understood the notice.

_____**Consent to Treat**
I hereby give my permission to Dr. G. Bryniczka, Dr. A. Bryniczka, Dr. S. Montes, Dr. D. O'Brian, Dr. B. Laubacher and their Assistants and Associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot-ankle condition(s).

_____ **Assignment of Insurance & Medicare Benefits**
I authorize payment of medical /Medicare benefits to be sent directly to Northwest Podiatry Center. I authorize Northwest Podiatry Center to furnish necessary information to my insurance company. I understand it is my responsibility to read and educate myself regarding my insurance companies or Medicare financial obligations, co-pay, deductibles, maximum limitations covered or non services, in net work/out of network benefits/co-insurance and obtain referrals and prior authorization of services.

_____**Patient Contact**
I give Northwest Podiatry Center permission to call me regarding test results, confirmation, re-scheduling of appointments, and discussion of my account. I give permission for messages to be left on my answering machine /cell phone or to be left with the persons answering the phone.

_____**Patient Financial Responsibility**
I understand Northwest Podiatry Center will file both primary and secondary insurance claims for me as a courtesy. I understand I am financially responsible for co-pays, deductibles, non-covered items/services at the time of my treatment. In the event my account is placed with a collection agency, I understand I will be responsible for the fees (balance owed plus 35%). I will be responsible for all court costs, filing fees, and attorney fees. I understand there will be a $15 charge for filling out disability forms that I will be responsible for. I understand there will be a $50 charge for broken or missed appointments. I understand I will be a $35 charge for returned checks or insufficient funds

_____ **Patient Consent to Photography/Films / Video**
I authorize Northwest Podiatry Centers and associates to photograph/film/video the treatment site for medical record purposes. In addition, I understand these materials may be used for teaching purposes which may include medical lectures, patient education, and website education. I am aware my name and identity will NOT be disclosed for privacy purposes.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print patient name