Podiatrist Comments/Summary ~ This box reserved for office use

Date__________ **DRS Signature** ______________________________ D.P.M.

New Patient Podiatric History Form

Dr. Kathleen T. Neuhoff

How did you learn of our office/who referred you to us:______________________

PLEASE PRINT

Patient Name ______________________________ Date ______________

Age __________ Height ______________ Weight __________ Shoe Size __________

CHIEF COMPLAINT ***(Nature of your Foot Pain or Problem):*** ______________________

____

____

Location on Foot or Leg:
check all that apply

- ☐ Forefoot/Toes
- ☐ Ankle
- ☐ Outer Side
- ☐ Middle Foot
- ☐ Top
- ☐ Inner Side
- ☐ Back Part of Foot
- ☐ Bottom

How Long Has This Bothered You? ______________________

How Did This Begin? ______________________

What Course has it Taken? ______________________

What Aggravates it? ______________________

What Makes it Feel Better? ______________________

What Have You Done to Relieve the Condition?______________________

(If you have gone to another doctor to relieve the pain, please give his/her name)

____

General Health: If you have had or have any Of the following, check all that apply

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Headaches
- ☐ Lower Back Pain
- ☐ Neck Pain
- ☐ HIV
- ☐ Hip Problems
- ☐ Ankle Problems
- ☐ Skin Problems
- ☐ Bone Fracture
- ☐ Pneumonia
- ☐ Bruise easily
- ☐ Breath shortness on exertion

Please CIRCLE all that apply:

Pain, Cramps, Swelling, Tingling

Burning in Feet—Numbness in Feet

Burning in Legs--- Numbness in Legs

This usually happens:

- ☐ after walking a block
- ☐ while lying in bed
- ☐ after being on feet

How long does this last? ________

Please turn this paper over and complete the questions on the back 03-12-2013

Date of your last Flu Shot:________________ Date of your pneumonia vaccination:__________
Can you take aspirin? _____ Have you had a local anesthetic *(such as for dental work)* ? ________
Did you have any problems with it? ______________________________
Please list the prescriptions that you take: ______________________________

____

____

Do you smoke? _______ How much? ________ For how long? ________
Do you drink? _______ How much? ________ For how long? ________
Are you using any over-the-counter medications? ______________________________
If so, which ones (names)? ______________________________

____

Past surgeries or hospitalizations: ______________________________

____

____

WOMEN: Are you, to your knowledge, Pregnant? ☐ Yes ☐ No

ALLERGIES

Are you allergic or sensitive to:

☐ Penicillin ☐ Novacaine ☐ Anesthetics
☐ Adhesive Tape ☐ Iodine ☐ Metal
☐ Drugs: ______________________________
☐ Other: ______________________________
☐ I am not allergic to anything that I know of.

FAMILY HEALTH

Have you or any of your family members ever had any of the following *(please check all that apply)*

You	Family		You	Family	
☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Heart Trouble	☐	☐	Nerve Disease
☐	☐	Blood vessel disease	☐	☐	Nervous Condition
☐	☐	High Blood Pressure	☐	☐	Muscle disease
☐	☐	Bleeding Problems	☐	☐	Bone disease
☐	☐	Kidney trouble	☐	☐	Varicose veins
☐	☐	Liver Problems	☐	☐	Arthritis
☐	☐	Anemia	☐	☐	Cancer
☐	☐	Lung disease	☐	☐	Rheumatic fever
☐	☐	Blood disease	☐	☐	Asthma
☐	☐	Lymph Disease	☐	☐	Gout

Any other medications not listed above? ______________________________

____

____

I certify that the above information is accurate and true to the best of my knowledge

Signature: ______________________________ **Date** ____________________

~ Thank You ~

Welcome to our office!

PLEASE PRINT

Today's Date ______________________

How did you hear about us? ______________________

Patient Name ______________________ Do you go by a nickname? ______________
Last First MI

Address ______________________ City ______________ ST ____ Zip ________

Date of Birth ___/___/___ SSN ______________________ Please circle one: Male Female

Email ______________________ Phone ______________ Cell ______________

Circle One: Single Married Widowed Separated Divorced
Race: African American Hispanic Caucasian Other
Preferred Language: English Spanish Other: ______________

Full time student? Yes No
Ethnicity: Hispanic Non-Hispanic

Occupation ______________________ Employer ______________________

Employer address ______________________
Street City State ZIP

Employer phone number ______________________ Extension ______________

Family Physician Name ______________________ Date of last visit ______________

Endocrinologist ______________________ Date of last visit ______________

Pharmacy Name ______________________ Location ______________________

Spouse's Name ______________________ Date of birth ___/___/___

SSN ____-___-_____ Employer Name ______________________

Employer address ______________________
Street City State ZIP

Employer phone number ______________________ Extension ______________

IN CASE OF EMERGENCY, PLEASE CONTACT: ______________________

Relationship ______________ Home phone ______________ Work phone ______________

Please read and sign regarding Treatment and Medical Records: I hereby give Dr. Neuhoff permission to release any information requested by my insurance company acquired in the course of my examination and treatment. I also give permission to release copies of my record to any healthcare provider at my request. I also permit the provider of my choice to administer treatment and perform such general procedures as he/she deems necessary in the diagnosis and/or treatment of my lower leg/foot condition(s).

Patient Signature ______________________ Date ______________

Patient signature required unless patient is under the age of 18; then a responsible party MUST sign.

Please read and sign regarding Financial Responsibility: I understand and agree that, regardless of my insurance coverage status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status, insurance coverage, or changes in any other of the above information.

Patient Signature ______________________ Date ______________

Patient signature required unless patient is under the age of 18; then a responsible party MUST sign.

Family Foot Care Clinic
727 E. Jefferson Boulevard, South Bend, IN 46617
(574) 287-5859 phone
(574) 287-4987 fax
www.familyfootcareclinic.com

FINANCIAL POLICY

Thank you for choosing Family Foot Care Clinic for your podiatry needs. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our financial policy.

Patient Name: ______________________________ Date of Birth: ______________

Please initial:

_____ All patients should provide accurate and complete demographic and Medicare card, if applicable. You may be asked to provide at each visit. Please provide new information if it has changed.

_____ **All applicable charges are due at time of service. We accept cash, checks and credit cards.**

_____ MEDICARE (Standard red, white and blue card)
We will file the charges, however, please note that we do not accept assignment; therefore, you are responsible for remitting payment at the time of service. You will be responsible for submitting claims to your supplemental insurance if it is not done automatically by Medicare.

_____ DELINQUENT ACCOUNTS
I/we agree to pay all attorney fees, court costs, filing fees and all collection costs that may be assessed by a collection agency retained to pursue your unpaid account balance. FFCC will make every effort to collect your balance prior to sending to collection. You may be dismissed from the practice for failure to comply to this policy.

_____ RETURNED CHECKS
For checks returned to us as unpaid and/or insufficient by the bank, we will charge a $25.00 fee.

_____ MISSED APPOINTMENTS
Office policy states that we will charge for missed appointments not cancelled 24 hours prior to your appointment. A $45.00 fee will be assessed and will be your responsibility. Help us to serve you better by keeping your scheduled appointment.

By signing below, I am acknowledging that I have read and understand the above financial policy and that any questions have been answered by the staff.

______________________________ ______________________________ ______________
Patient name - *please print* Patient signature Date

____
Staff Signature

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Family Foot Care Clinic

727 East Jefferson
South Bend, IN 46617
574-287-5859

Notice of Privacy Practices

ACKNOWLEDGMENT FORM

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 so chose) and understood the Notice.

Patient Name (please print) ______________________ Date ____________

Parent or Authorized Representative (if applicable) ______________________

Signature ______________________

I authorize Family Foot Care Clinic to share ☐ ***Clinical and/or*** ☐ ***Financial*** information with:

Name ______________________ Relationship ____________

Name ______________________ Relationship ____________

Name ______________________ Relationship ____________