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P

Medical Problems

1.) _____ 4.) _____ T _____
2.) _____ 5.) _____ BP _____
3.) _____ 6.) _____ []

PAST SURGICAL HISTORY:

[]

FAMILY HISTORY:

[]

SOCIAL HISTORY: Tobacco _____ **Yes** _____ **No,** **Packs/Day** _____ **Years** _____ []
Alcohol _____ **Yes** _____ **No,** **Drinks/Day** _____ **Years** _____
[]

ALLERGIES:

___ Penicillin ___ Morphine ___ Adhesive tape ___ Aspirin ___ Any Chemicals []
___ Sulfa drugs ___ Antibiotics ___ Any foods ___ Codeine ___ Other Drugs
___ Other _____ [] **NKDA**

REVIEW OF SYSTEMS:

INITIAL PODIATRIC HISTORY (Check appropriate boxes)

___ Poor appetite ___ Excessive hunger ___ Difficult chewing ___ Difficulty swallowing
___ Excessive thirst ___ Nausea ___ Vomiting food ___ Abdominal pain
___ Constipation ___ Black stool ___ Bloody stool ___ Diarrhea
___ Hemorrhoids ___ Liver trouble ___ Gallbladder trouble ___ Weight loss []
___ Belching ___ Stomach trouble ___ Appendicitis ___ Indigestion
___ Gas ___ Weight gain ___ Ulcers ___ Other
___ Bladder trouble ___ Excessive urination ___ Scanty urination ___ Painful urination
___ Frequent urination ___ Prostate trouble ___ Kidney disease ___ Blood in urine []
___ Difficult urination ___ Discolored urine ___ Kidney stones

Patient Last Name: _____ DOB: _____

REVIEW OF SYSTEMS (CON'T):

NEUROLOGY

Numbness Loss of feeling Paralysis Dizziness
 Muscle jerking Convulsions Forgetfulness Depression []
 Fainting Confusion Headaches Spine disease
 Stroke Weakness Seizure Brain disease Other

RESPIRATORY

Persistent cough Difficult breathing Bronchitis Lung problems
 Coughing blood Emphysema Coughing problem []
 Asthma Shortness of breath Wheezing Hay fever Other

DERMATOLOGY

Itching Psoriasis Bruises Skin rash
 Abrasions Ulcerations Moles Discolorations []
 Skin cancers Deformed nails Birth marks Eczema Hives Other

MUSCULOSKELETAL

Arthritis Stiffness Club foot Joint disease
 Bursitis Fractures Muscle pain Lumbago []
 Sprains Sciatica Other

 Anemia Jaundice Bleeding disorder Other

COMMENTS:

Patient Last Name: _____ DOB: _____

PITTSBURGH FAMILY FOOT CARE, P.C.

FINANCIAL POLICY

Our practice is committed to providing quality medical care for you. Please understand that payment of your bill is considered part of your commitment to quality care. Full payment is due at time of service for non-covered charges unless other arrangements have been made, and co-payment is due at the time of the appointment.

We accept cash, checks, MasterCard and Visa for office visit payments. We also offer an extended payment plan with prior approval. Benefit assignment is accepted from several insurance companies. Please check with us regarding your individual company.

We participate with various PPO's and HMO's. Please inquire as to our participation with your current health care plan and as to whether a referral is necessary. If your health plan requires a referral from a primary care physician and you have not obtained this referral, you will be responsible for all charges related to our services.

CUSTOM ORTOTICS MAY OR MAY NOT BE COVERED BY YOUR INSURANCE. THE PATIENT IS RESPONSIBLE FOR ALL CHARGES RELATED TO THE CUSTOM ORTHOTICS IF NOT PAID BY INSURANCE COMPANY. DEPOSITS FOR CUSTOM ORTOTICS OR SHOES ARE NOT REFUNDABLE ONCE PRODUCTION OF THE PRODUCT HAS STARTED.

As a courtesy to our patients, we will submit claims to insurance companies for any procedures done in the office. If you have a deductible to meet, we will be glad to issue you a receipt that you can forward to your insurance company. You are responsible for payment not covered by your insurance. If your insurance carrier has not paid your account in full within 45 days, the balance due will be charged to you.

Thank you for understanding our financial policy. Any questions will be handled by our business office at (724) 941-9440. Please contact the office if you have any questions or concerns.

PATIENT SIGNATURE _____

DATE _____

PAYMENT AUTHORIZATION

I request that payment of authorized Medicare/Primary Insurance carrier benefits be made either to me or on my behalf to PITTSBURGH FAMILY FOOT CARE, P.C. for any service furnished to me by that physician or supplier. I authorize any holder of my medical information 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.

BENEFICIARY SIGNATURE _____

DATE _____

MEDIGAP/SECONDARY CARRIER

I request payment of authorized Medigap/Secondary Insurance Carrier benefits be made either to me or on my behalf to PITTSBURGH FAMILY FOOT CARE, P.C. for any services furnished me by that physician or supplier. I authorize any holder of my medical information to release to my insurance companies any information needed to determine the benefits payable for related services.

BENEFICIARY SIGNATURE _____

DATE _____

**ACKNOWLEDGEMENT 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 understand the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature