Patient Initials____________
Date:_____/_____/______
Account Number:__________

PITTSBURGH FAMILY FOOT CARE, P.C.

PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: ______________ ______________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: ________________________________ CITY/STATE: ____________________ ZIP: __________

PRIMARY PHONE: (____) ______-____________ SECONDARY #: (____) __________-______________

MAY WE LEAVE A MESSAGE? YES NO

E-MAIL:____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

WHO ELSE ARE WE AUTHORIZED TO SHARE INFORMATION WITH:
____

PRIMARY LANGUAGE: _____________________ ETHNICITY: (NATIONALITY)___________________

RACE: AMER. IND./ALASKAN AFR. AMERICAN ASIAN HISPANIC OR LATINO CAUCASIAN OTHER

PRIMARY CARE DOCTOR: ____________________________________ PHONE: ____________________________

LAST PCP VISIT DATE: ______________________________________

EMERGENCY CONTACT: _______________________ RELATIONSHIP: __________ PHONE #: (____) ____-______

HOW DID YOU HEAR ABOUT THE PRACTICE? ____

INSURANCE INFORMATION: YOU MUST SUPPLY PROOF OF INSURANCE AT THE TIME OF VISIT SUCH AS YOUR INSURANCE CARD OR PROOF OF ID SUCH AS A DRIVER'S LICENSE. IF WE DO NOT HAVE PROOF OF INSURANCE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF VISIT.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

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____ PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____ IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____ SIGNATURE

____ DATE

Pharmacy:__________________ Location:____________________ Phone:______________________

MEDICATION (INCLUDING OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS)	**STRENGTH**	**FREQ.**

ALLERGIES:

☐ NO KNOWN DRUG ALLERGIES

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER

____

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☐ FOODS ____________________________

☐ MEDICATIONS & INJECTABLES ____

REVIEWED BY:________________

Shoe Size:_________ Current Weight:________ Height:________________

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE __________________

☐ CURRENT USE - TYPE _____________ ☐ OCCASIONAL ☐ MODERATE ☐ DAILY ☐ OPIOID ABUSE

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES	Y	N	FIBROMYALGIA	Y	N	STROKE	Y	N
PVD	Y	N	GOUT	Y	N	THYROID DISEASE	Y	N
NEUROPATHY	Y	N	HEART ATTACK/DISEASE	Y	N	SKIN DISORDER	Y	N
ANEMIA	Y	N	HEART DISEASE/FAILURE	Y	N	PNEUMONIA	Y	N
ARTHRITIS	Y	N	HEPATITIS B OR C	Y	N	MIGRAINE HEADACHES	Y	N
ASTHMA	Y	N	HIV+/AIDS	Y	N	CANCER	Y	N
BACK TROUBLE	Y	N	HIGH BLOOD PRESSURE	Y	N	LOW BLOOD PRESSURE	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	KIDNEY DISEASE	Y	N	ACID REFLUX/STOMACH ULCERS	Y	N
BLADDER INFECTIONS	Y	N	LIVER DISEASE	Y	N			

OTHER CONDITIONS: ____

WHO MANAGES THESE CONDITIONS:______________________________________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER
____

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PLEASE LIST ALL PRIOR SURGERIES WITHIN THE LAST 10 YEARS:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

____
____
____
____
____
____

DO YOU HAVE A HISTORY OF MRSA:____________________

REVIEWED BY:_________________

CURRENT PROBLEM

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ___________________________________

LOCATION OF THE PAIN: RIGHT FOOT LEFT FOOT BOTH FEET (PLEASE CIRCLE)

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** ***(WORST PAIN POSSIBLE)***

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ OTHER
____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?
____

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WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?
____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?
____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

EMPLOYER: _________________________OCCUPATION:_______________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE:
____

REVIEWED BY:__________

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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 that I understand the notice.

______________________________________ ______________________________________
Patient Name (PLEASE PRINT) **Date**

____
Parent or Authorized Representative (if applicable)

____
Signature

Patient Initials____________
Date:_____/_____/______
Account Number:__________

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, and credit cards for office visit payments and all related charges. We also offer an extended payment plan with prior approval. An advance beneficiary notice will be provided to all Medicare patients for non-covered services.

Invoices are sent out on a regular basis. If a balance remains unpaid, you may be notified by certified mail that you have 30 days to find alternative podiatric care. During that 30 day period your physician will only be able to treat you on an emergency basis.

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

Medical products dispensed such as creams, lotions, medical equipment items (such as heel cups, , splints, etc.), non custom innersoles are not returnable once they are taken outside of the office.
.

Late Cancellations/No Show Policy for appointments in a continuous 6 month period:

A late cancellation **is considered when a patient fails to cancel their scheduled appointment with a 24-hour notice. If late cancellation becomes a repetitive issue with a patient, a late cancellation fee ($30.00) may be billed directly to you.**
A "no-show**" is someone who misses an appointment without cancelling it in a reasonable amount of time. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".**

NO SHOW RATES:

- **First missed appointment: there will be no charge**
- **Additional missed appointments: $30.00 fee will be billed directly to you.**

We charge a $15.00 fee for completion of all forms , such as disability / work related forms.

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 60 days, the balance due will be charged to you.
Questions regarding our financial policy will be handled by our business office at (724) 941-9440 Ext 202.

I have read and understand the payment policy and agree to abide by the guidelines listed above. .

PATIENT SIGNATURE:______________________________ **DATE:**______________________

RELEASE OF INSURANCE PAYMENT

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.

PATIENT 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.

PATIENT SIGNATURE:________________________ **DATE:**______________________