David Linde, D.P.M. | David Campbell, D.P.M.
www.bhamfoot.com

PATIENT INFORMATION

DATE ________________________ SS# ___________________________________

PATIENT NAME ____ BIRTH DATE _______________________

ADDRESS ____

HOME PHONE _________________________ WORK PHONE _______________________ CELL PHONE ____________________

EMAIL ADDRESS ____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] PARTNERED [ ] SEPARATED [ ] DIVORCED [ ] WIDOWED

RACE: [ ] ASIAN [ ] BLACK [ ] HISPANIC [ ] NATIVE AMERICAN [ ] WHITE

PRIMARY LANGUAGE: [ ] ENGLISH [ ] SPANISH [ ] OTHER ______________________

EMPLOYER ____ PHONE __________________________________

FAMILY PHYSICIAN____ PHONE __________________________________

PHARMACY ____ PHONE __________________________________

EMERGENCY CONTACT _______________________________________ PHONE __________________________________

INSURANCE (IF POLICY HOLDER IS NOT THE PATIENT PLEASE COMPLETE)

PRIMARY INSURANCE _____________________________________ POLICY HOLDER'S RELATIONSHIP _________________

SS# OF POLICY HOLDER ___________________________________ DOB OF POLICY HOLDER ________________________

SECONDARY INSURANCE ___________________________________ POLICY HOLDER'S RELATIONSHIP _________________

SS# OF POLICY HOLDER ___________________________________ DOB OF POLICY HOLDER ________________________

HOW DID YOU HEAR ABOUT US? [ ] INTERNET [ ] PHYSICIAN (name) ___________________________

[ ] FRIEND/FAMILY (name) ___________________________ [ ] OTHER __________________

SOCIAL HISTORY

DO YOU SMOKE?
[ ] NEVER [ ] SOCIAL [ ] EVERYDAY [ ] QUIT - HOW LONG AGO? _______ SMOKE(D) ____PACKS/DAY FOR ______ YEARS

DO YOU DRINK ALCOHOL? [ ] Y [ ] N IF YES, HOW MUCH AND HOW OFTEN? _________________________________

DO YOU USE RECREATIONAL DRUGS? [ ] Y [ ] N

DO YOU EXERCISE REGULARLY? [ ]Y [ ]N IF YES, WHAT TYPE? ____

ALLERGIES

[ ] NO KNOWN DRUG ALLERGIES
[ ] PENICILLIN
[ ] SULFA
[ ] CODEINE
[ ] MORPHINE
[ ] LORTAB
[ ] NSAIDs
[ ] SHELLFISH
[ ] IODINE
[ ] ADHESIVE TAPE
[ ] LOCAL ANESTHETICS
[ ] LATEX
[ ] OTHERS: _______________
____

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER HAD ANY OF THE FOLLOWING (PLEASE INDICATE RELATIONSHIP) (I.E. MOTHER, FATHER, GRANDPARENTS, SIBLINGS OR CHILDREN)

[ ] BLEEDING DISORDER
[ ] CANCER
[ ] DIABETES: TYPE 1 OR TYPE 2
[ ] GOUT
[ ] HEART DISEASE
[ ] HIGH BLOOD PRESSURE
[ ] PERIPHERAL VASCULAR DISEASE (PVD)
[ ] RHEUMATOID ARTHRITIS
[ ] OTHER ____________________________
____

PAST MEDICAL HISTORY

[ ] NO MEDICAL PROBLEM

HEART / CARDIAC HISTORY

[ ] ARTIFICIAL HEART VALVES
[ ] HEART ATTACK (MYOCARDIAL INFARCTION)
[ ] HEART ARRHYTHMIA (A-FIB)
[ ] HEART ARTERY BLOCKAGE (CAD)
[ ] HEART FAILURE (CHF)
[ ] HYPERTENSION (HIGH BLOOD PRESSURE)
[ ] HYPOTENSION (LOW BLOOD PRESSURE)
[ ] MITRAL VALVE PROLAPSE / MURMUR
[ ] OTHER HEART PROBLEM – TYPE ___________________

CIRCULATORY HISTORY

[ ] PERIPHERAL VASCULAR DISEASE (PVD)
[ ] VARICOSE VEINS /DVT
[ ] OTHER CIRCULATION PROBLEMS – TYPE________________________________

LUNGS / PULMONARY DISEASE

[ ] ASTHMA
[ ] BRONCHITIS
[ ] COPD
[ ] CANCER – TYPE ________________________
[ ] EMPHYSEMA
[ ] SLEEP APNEA

METABOLIC ILLNESS / ENDOCRINE

[ ] DIABETES
[ ] TYPE I [ ] TYPE II [ ] DIET CONTROLLED
[ ] HIGH CHOLESTEROL
[ ] HYPERTHYROIDISM (OVER ACTIVE THYROID)
[ ] HYPOTHYROIDISM (UNDER ACTIVE THYROID)
[ ] CANCER – TYPE ________________________

BLOOD DISEASES / HEMATOLOGY

[ ] AIDS/HIV
[ ] ANEMIA
[ ] BLEEDING DISORDERS / HEMOPHILIA
[ ] BLOOD CLOTS
[ ] CANCER – TYPE ________________________
[ ] HODGKIN'S DISEASE
[ ] NON HODGKIN'S DISEASE

LIVER / HEPATIC DISEASE

[ ] HEPATITIS / JAUNDICE
[ ] LIVER PROBLEM – TYPE _________________________
[ ] CANCER – TYPE ________________________

KIDNEYS / GENITOURINARY / REPRODUCTIVE DISEASE

[ ] DIALYSIS
[ ] KIDNEY DISEASE – TYPE ________________________
[ ] CANCER – TYPE ________________________

STOMACH / BOWELS / GASTROINTESTINAL DISEASE

[ ] GERD (GASTROESOPHAGEAL REFLUX)
[ ] STOMACH ULCERS
[ ] CANCER – TYPE ________________________

HEAD / EYES /EARS / NOSE / THROAT

[ ] EAR PROBLEMS / HEARING
[ ] HEADACHES / MIGRAINES
[ ] SINUS PROBLEMS
[ ] VISION PROBLEM
[ ] CANCER – TYPE ________________________

BONE OR JOINT PAIN / MUSCULOSKELETAL

[ ] ARTHRITIS
TYPE: [ ] RHEUMATOID [ ] OSTEO [ ] GOUT
[ ] LUPUS [ ] PSORIATIC
[ ] ARTIFICAL JOINTS
[ ] BACK PROBLEMS – TYPE ___________________
[ ] CANCER – TYPE ________________________

NEUROLOGICAL / PSYCHIATRIC

[ ] EPILEPSY (SEIZURES)
[ ] FAINTING
[ ] NEUROPATHY
[ ] PSYCHIATRIC CARE
[ ] STROKE

SKIN / INTEGUMENT

[ ] RASH
[ ] CANCER – TYPE ________________________

SURGICAL HISTORY

CARDIAC / HEART
[ ] OPEN HEART BYPASS
[ ] ANGIOPLASTY WITH/WITHOUT STENTS
[ ] VALVE REPLACEMENT
[ ] ABLATION
[ ] PACEMAKER
[ ] DEFIBRILLATOR
[ ] HEART – TYPE ________________________

PERIPHERAL VASCULAR
[ ] BYPASS
[ ] BALLOON ANGIOPLASTY WITH/WITHOUT STENTS
[ ] VEIN STRIPPING / LIGATION

LUNGS
[ ] PARTIAL / COMPLETE REMOVAL OF EITHER LUNG
[ ] BRONCHOSCOPY

LIVER
[ ] GALL BLADDER
[ ] PANCREAS

GI / STOMACH BOWELS
[ ] APPENDECTOMY
[ ] BOWEL RESECTION
[ ] GASTRIC BYPASS / SLEEVE
[ ] ULCERS
[ ] HERNIA REPAIR
[ ] COLOSTOMY

GENITOURINARY
[ ] C-SECTION
[ ] MASTECTOMY
[ ] HYSTERECTOMY – PARTIAL
[ ] HYSTERECTOMY – TOTAL
[ ] PROSTATE REMOVAL
[ ] KIDNEY STONES
[ ] TUBAL LIGATION
[ ] KIDNEY REMOVAL / NEPHRECTOMY

MUSCULOSKELETAL
[ ] BACK
[ ] HIP
[ ] KNEE
[ ] SHOULDER
[ ] HAND
[ ] FOOT /ANKLE SURGERY
[ ] JOINT REPLACEMENT
[ ] OTHER JOINT SURGERY _________________

SKIN
[ ] MALIGNANT MELANOMA
[ ] BASAL CELL CARCINOMA
[ ] SQUAMOUS CELL CARCINOMA
[ ] WARTS
[ ] CYSTS

NEUROLOGICAL
[ ] BRAIN TUMOR
[ ] BRAIN SURGERY
[ ] CAROTID SURGERY
[ ] SUBDURAL HEMATOMA
[ ] CARPAL TUNNEL
[ ] SPINAL CORD STIMULATOR

HEALTH REVIEW

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD IN THE PAST 3 MONTHS

GENERAL: [ ] FEVER [ ] CHILLS [ ] NAUSEA [ ] VOMITING [ ] FATIGUE [ ] WEIGHT LOSS [ ] WEIGHT GAIN
[ ] NO PROBLEMS

HEAD: [ ] HEADACHE [ ] VISUAL PROBLEMS [ ] HEARING PROBLEMS [ ] DIZZINESS [ ] NO PROBLEMS

CARDIOVASCULAR: [ ] CHEST PAIN [ ] PALPITATIONS [ ] SWELLING OF LEGS
[ ] OTHER: __________________ [ ] NO PROBLEMS

HEMATOLOGY: [ ] ANEMIA [ ] ABNORMAL BLEEDING/BRUISING [ ] BLOOD CLOTS [ ] BLEEDING DISORDERS
[ ] OTHER: __________________ [ ] NO PROBLEMS

RESPIRATORY: [ ] PERSISTANT COUGH [ ] WHEEZING [ ] SHORTNESS OF BREATH [ ] NO PROBLEMS

GASTROINTESTIONAL: [ ] DIFFICULTY SWALLOWING [ ] INDIGESTION / HEARTBURN [ ] ABDOMINAL PAIN
[ ] CHANGE IN BOWELS [ ] NO PROBLEMS

HEALTH REVIEW (CONTINUES)

URINARY: [ ] PAINFUL URINATION [ ] FREQUENT URINATION [ ] URINARY TRACT INFECTION
[ ] OTHER: __________________ [ ] NO PROBLEMS

MUSCULOSKELETAL: [ ] JOINT PAIN / SWELLING / STIFFNESS [ ] LOWER BACK PAIN [ ] MUSCLE WEAKNESS
[ ] UPPER BACK PROBLEMS [ ] DIFFICULTY WALKING [ ] NO PROBLEMS

SKIN: [ ] RASH [ ] SUSPICIOUS LESION [ ] ITCHING [ ] NO PROBLEMS

NEUROLOGICAL: [ ] NUMBNESS OF HANDS & FEET [ ] SEIZURES, TREMORS [ ] PARALYSIS [ ] NO PROBLEMS

PSYCHIATRIC: [ ] DEPRESSION [ ] ANXIETY [ ] PROBLEMS SLEEPING [ ] MEMORY LOSS [ ] NO PROBLEMS

ENDOCRINE: [ ] HEAT / COLD INTOLERANCE [ ] HOT FLASHES [ ] CHANGE IN HAIR / SKIN TEXTURES [ ] EXCESSIVE THIRST
[ ] EXCESSIVE URINATION [ ] NO PROBLEMS

MEDICATION **(PRESCRIBED AND OVER THE COUNTER)**
[ ] NOT CURRENTLY TAKING MEDICATION

1. ______________________________ **9.** ______________________________

2. ______________________________ **10.** ______________________________

3. ______________________________ **11.** ______________________________

4. ______________________________ **12.** ______________________________

5. ______________________________ **13.** ______________________________

6. ______________________________ **14.** ______________________________

7. ______________________________ **15.** ______________________________

8. ______________________________ **16.** ______________________________

PODIATRIC HISTORY

[ ] BUNIONS [ ] ATHLETES FOOT [ ] HEEL / ARCH PAIN

[ ] DIABETIC FOOT ULCER [ ] INGROWN NAILS [ ] PLANTAR WART

[ ] ACHILLES TENDON PAIN [ ] BACK PAIN [ ] DISCOLORATION OF TOES / FEET

[ ] FEET / TOES NUMB [ ] DIFFICULTY WALKING OR RUNNING [ ] ANKLE PAIN

SHOE SIZE ____________

CURRENT FOOT PROBLEM

HOW LONG AGO DID THIS PROBLEM FIRST START? _______ [ ] DAY(S) [ ] WEEK(S) [ ] MONTH(S) [ ] YEAR(S)

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

HOW WOULD YOU DESCRIBE YOUR PAIN? [ ] NO PAIN [ ] SHARP [ ] DULL [ ] ACHING [ ] BURNING [ ] RADIATING
[ ] ITCHING [ ] STABBING [ ] OTHER ____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (0 IS NO PAIN AND 10 IS WORST PAIN POSSIBLE)

NO PAIN [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 **SEVERE PAIN**

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

WAS THIS PROBLEM CAUSE BY AN INJURY? [ ] YES [ ] NO
IF YES, WAS IT A WORK-RELATED INJURY? [ ] YES [ ] NO

AUTHORIZATION

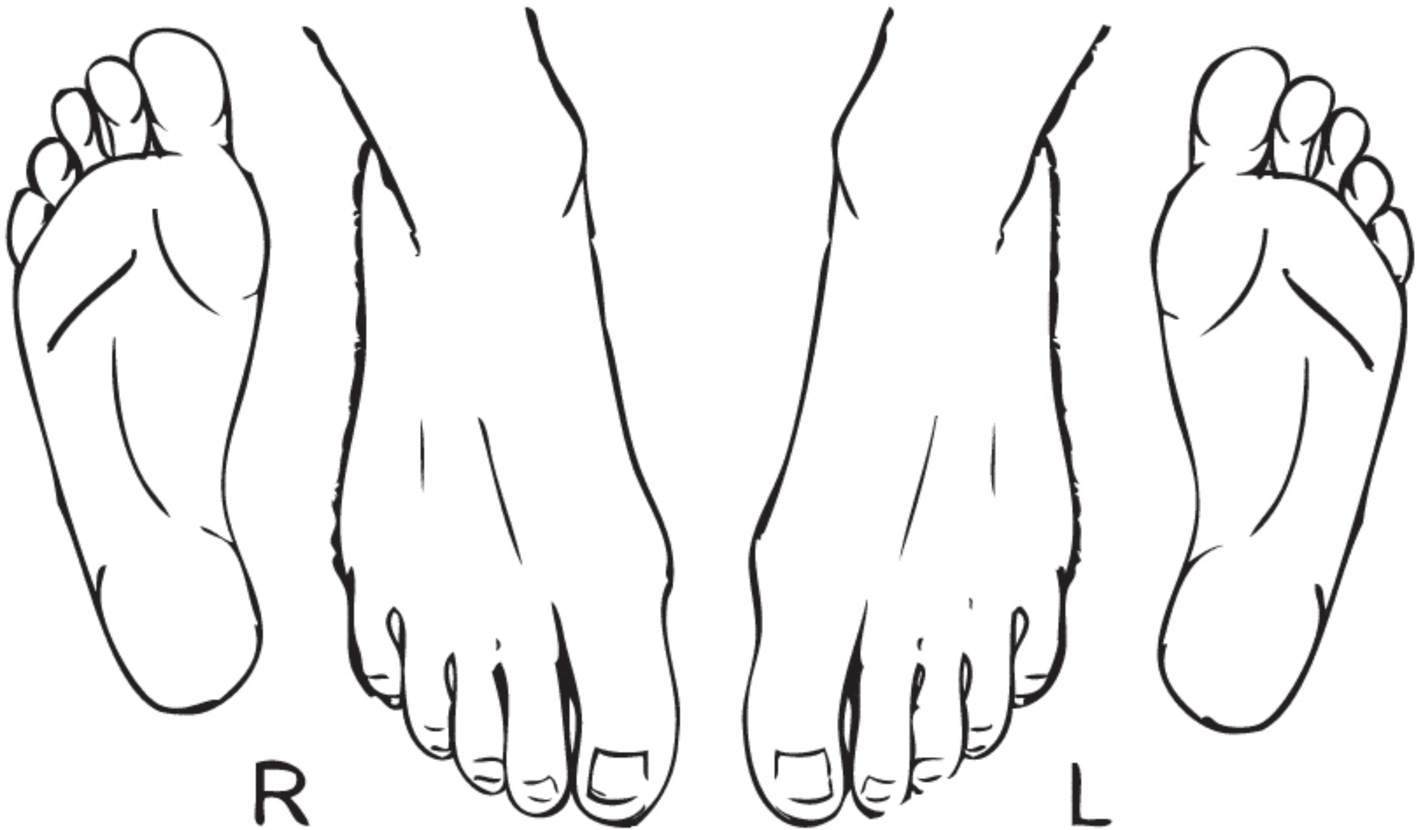
I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there are any changes in my medical condition I will inform the doctor. I also authorize my insurance company to pay the doctor or medical group for all insurance benefits, otherwise benefits are payable by me for services rendered. I authorized use of this signature on all insurance submissions as well as unsigned forms needed for diagnostic purposes.

____ ______________________________
Signature of Patient or Personal Representative **Date**

____
Relationship of Personal Representative to the Patient

____ ______________________________
Print Patient's Name **Print Personal Representative's Name**

PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN / PROBLEMS



INTIAL ______________________________ DATE______________________________

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEGEMENT
(PLEASE PRINT)

Patient Name ____ Date of Birth ___________________________

Patient's Address ____ SSN ______________________________

____

I give Foot Specialists of Birmingham, P.C. permission to release medical information to the following person:

- None
- Parents ________________________________
- Spouse _________________________________
- Father (only) ____________________________
- Mother (only) ___________________________
- Other __________________________________
- Guardian ______________________________

I wish to be contacted in the following manner by Foot Specialists of Birmingham, P.C. (check all that applies):

- **Home Telephone ___(   )________-____________**
  ___O.K. to leave a message with detailed information
  ___Leave message with call back number only
- **Work Telephone ___(   )________-_____________**
  ___O.K. to leave a message with detailed information
  ___Leave message with call back number only
- **Written Communication**
  ___O.K. to mail to my home address or email to personal email
  ___O.K. to mail to my work / office or email to business email
  ___O.K. to fax to this number ___(   )________-_____________
  ___Other email address _________________________________

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and request for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

CONSENT:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without consent in an emergency.

ACKNOWLEDGEMENT:
I acknowledge that I have received Foot Specialists of Birmingham, P.C. Notice of Privacy Practices.

____ ____________________________
Signature of Patient or Personal Representative **Date**

____ ____________________________
Relationship of Personal Representative to the Patient **Signature of Witness**

____
Print Personal Representative's Name

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skilled and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. *Patients are responsible for paying annual deductible if it has not yet been met*. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

SELF-PAY ACCOUNTS: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

REFERRALS / AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for services received, unless your referral is presented at the time of visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company.**

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies there is a co-insurance or deductible that we were not aware of at the time of service. You will be sent **three (3)** notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the follow payment methods: Cash, Check and VISA/MasterCard.

COLLECTIONS: You agree, in order for us and any third-party collection agency to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or email, using any email address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

- **An additional $20 fee will be added to your account if we have to bill you for fees due at the time of service. This includes co-pay, deductible, co-insurance and non-covered services based on your insurance benefit information at the time of service.**
- **An additional $35 will be added to your statement if the check is returned for insufficient funds (NSF).**

I have read the above policy regarding my *financial responsibility* to Foot Specialists of Birmingham, P.C. for medical services provided. I agree to pay Foot Specialists of Birmingham, P.C. any balance unpaid by my insurance carrier for myself or the below named person.
ASSIGNMENT OF BENEFITS:
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Foot Specialists of Birmingham, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or request physician to provide continuity of care. I authorize the use of this signature on all insurance submission.

Patient Signature: ______________________________ Date: ______________

FINANCIALLY RESPONSIBLE PARTY

Signature: ______________________________ Relationship to Patient: ______________ Date: ____________