Name _____Date of Birth _____Age _____

Primary Care Physician: _____Last visit: _____

Height: _____ Weight: _____ Shoe Size: _____

Past Medical History: Please indicate if you have any of the following

☐ Anemia	☐ Deep Vein Thrombosis	☐ Hyperlipidemia	☐ RENAL DISEASE
☐ Anesthesia Complications	☐ Diabetes- Type 1	☐ Hypertension	☐ Rheumatoid Arthritis
☐ Asthma	☐ Diabetes- Type 2	☐ Kidney Disease	☐ Seizure Disorder
☐ Autoimmune Disorder	☐ Dialysis	☐ M I	☐ Sickle Cell
☐ Cancer	☐ Foot Ulcer	☐ MRSA	☐ Swelling
☐ Congestive Heart Failure	☐ GOUT	☐ Neuropathy	☐ Thyroid Disorder
☐ Coronary Heart Disease	☐ Hemophilia	☐ Osteoarthritis	☐ Tuberculosis
☐ C V A/ Stroke	☐ Hepatitis	☐ Osteoporosis	☐ Varicose Veins/ Phlebitis
☐ Depression	☐HIV	☐ PVD	

Family History: Mother: Alive Age _____ Deceased Age _____ Any Medical Problems _____

Father: Alive Age _____ Deceased Age _____ Any Medical Problems _____

Has any immediate family member ever had an allergic reaction to anesthesia? Yes No Describe : _____

Social History:

Smoking Status: Current ☐ Former ☐ Never ☐ ☐ Drug Use ☐ Regular Exercise ☐ Religion Affecting Care

☐ History of Domestic Abuse ☐ HIV/High Risk ☐ Alcohol Use

Review of Symptoms:

☐ Fever	☐ Chest Pain	☐ Joint Swelling	☐ Paresthesias
☐ Chills	☐ Leg Swelling	☐ Muscle Weakness	☐ Frequent Falls
☐ Sweats	☐ Palpitations	☐ Leg Pain at Night	☐ Difficulty Walking
☐ Anorexia	☐ Shortness of Breath	☐ Leg Pain with Exertion	☐ Polydipsia
☐ Fatigue	☐ Abdominal Pain	☐ Open Lesions	☐ Polyphagia
☐ Weakness	☐ Black/Tarry Stools	☐ Rash	☐ Polyuria
☐ Weight Loss	☐ Urinary Frequency	☐ Itching	☐ Unusual Weight Change
☐ Vision Problems	☐ Nocturia	☐ Dryness	☐ Abnormal Bruising
☐ Decreased Hearing	☐ Incontinence	☐ Suspicious Lesions	☐ Bleeding
☐ Dizziness	☐ Foot or Ankle Joint Pain	☐ Paralysis	☐ Enlarged Lymph Nodes
☐ Urticaria	☐ Allergic Rash	☐ Recurrent Infections	

5) PAST SURGICAL HISTORY: _____

_____

6) MEDICATIONS: _____

_____

7) ALLERGIES: _____**8) Reason for visit today:** _____

The above is true to the best of my knowledge.

Patient Signature: _____ Date: _____

DEMOGRAPHICS & INSURANCE

Name: _____

SS#:_____Date of Birth:_____Sex: ☐ Male ☐Female

Mailing Address: _____

City_____ State_____ Zip Code: _____

Home Phone Number:_____ Mobile Phone Number: _____

Mobile Carrier: _____ **Email:** _____

Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Text ☐ Email

☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled

Employer:_____Work Phone: _____

Emergency Contact Name/Phone Number: _____

Primary Language: ☐ English ☐ Spanish ☐ Other Ethnicity: ☐ Hispanic/Latino ☐ not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/ Pacific Islander ☐ White

Are you a student: ☐ Yes ☐ No Marital Status: ☐ S ☐ M ☐ D ☐W

Financially Responsible Party Information (if different than patient)

Name: _____ Relationship: _____

SS#: _____ DOB:_____Phone Number: _____

Address: _____

Insurance Information

Primary Insurance: _____ Insured ID: _____

Secondary Insurance: _____ Insured ID: _____

Insurance Subscriber Information (if different than patient)

Name: _____SS#: _____DOB:_____ Relationship:_____

Authorization to Disclose Health Information

By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history.

Name: _____ Relationship: _____

May disclose (select all that apply): ☐ Billing Information ☐ Medical Information ☐ Appointment Information

Name: _____ Relationship: _____

May disclose (select all that apply): ☐ Billing Information ☐ Medical Information ☐ Appointment Information

FINANCIAL POICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill 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 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. We accept Medicare benefit amounts. 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 their annual deductible if it has not yet been met. You are also responsible for any copayments, 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 (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: 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 full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us 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 the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

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: ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: We do not accept returns on any Durable Medical Equipment or supplies that is dispensed from our office.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Mark J. Henson, DPM, PC./Field Foot and Ankle Clinic for medical services provided. I agree to pay Mark J. Henson, DPM, PC./Field Foot and Ankle Clinic any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

MEDICATION HISTORY CONSENT: By signing below I give permission for Mark J. Henson, DPM/Field Foot and Ankle Clinic to download a historic list of all medications prescribed for a patient by any provider through SureScripts Medication History for Reconciliation.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Mark J. Henson, DPM, PC./Field Foot and Ankle Clinic** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. 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 requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name:_____ **Signature:** _____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:

PRINT Name: _____

Relationship to Patient: _____

Signature:_____

Date: _____

PAIN SURVEY

Name: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- ☐ Flat Feet
- ☐ Poor coordination
- ☐ Heel or Arch Pain
- ☐ Leg pain (shin splints)
- ☐ Achilles tendon pain
- ☐ Discoloration of toes/foot
- ☐ Ankle swelling or stiffness
- ☐ Pain in feet or legs with exercise
- ☐ Foot/Toes/Legs Burn
- ☐ Pain in feet getting out of bed
- ☐ "Toe-in" or "Toe-out" gait (walking)
- ☐ Pain or fatigue of feet or legs in activit
- ☐ Ankle instability (easy twisting injuries
- ☐ Difficulty/Pain with brisk walking or ru
- ☐ Pain legs occurs at the same distance e
- ☐ Coldness in the legs or feet that is unc
- ☐ Non / Poor healing sore on the leg or f
- ☐ Feet/Toes feel numb

Do the above conditions disrupt your lifestyle and activities of daily living? ☐ Yes ☐ No

Are you suffering with any of the following:

Tingling/Numbness in:	☐ Legs	☐ Ankles	☐ Feet
Pain radiating into:	☐ Ankles	☐ Feet	☐ Toes
Weakness of the:	☐ Legs	☐ Ankles	☐ Foot
Difficulty with:	☐ Standing	☐ Walking	☐ Sitting
	☐ Bending	☐ Lifting	☐ Kneeling

How long have you been suffering with this condition? ☐ Days ☐ Weeks ☐ Months ☐ Longer

Is this condition affecting your ability to perform daily tasks? ☐ Yes ☐ No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what like to do today.

☐ I would like to discuss the above conditions with the Doctor so I can make an educated decision about

☐ If available, I would be open to have a medical test to further evaluate my problem.

Patient Signature: _____