Intake and History Form

Sims & Associates Podiatry

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Insurance (Primary)_____ Policy ID:_____Policy Holder:_____

Insurance (Secondary)_____ Policy ID:_____Policy Holder:_____

Referring Provider & Primary Provider

Referring Providers Name: _____

Phone Number: _____

City or Zip Code: _____

Date Last seen: ____/____/____

Primary Providers Name: _____

Phone Number: _____

City or Zip Code: _____

Date Last seen: ____/____/____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

MedicaHistory

Select any of the following medical conditions you currently have:

☐ None	☐ Disease caused by 2019-nCoV	☐ Leukemia
Anxiety disorder	Elevated blood pressure	Malignant lymphoma
☐ Arthritis	☐ End-stage renal disease	☐ Malignant tumor of breast
Asthma	Epilepsy	Malignant tumor of colon
☐ Atrial fibrillation	☐ Gastroesophageal reflux disease	☐ Malignant tumor of lung
Benign prostatic hyperplasia	H/O: hypertension	Malignant tumor of prostate
☐ Cerebrovascular accident	☐ Hearing loss	☐ Radiation therapy treatment management
Chronic obstructive lung disease	Human immunodeficiency virus infection	Transplantation of bone marrow
☐ Coronary arteriosclerosis	☐ Hypercholesterolemia	☐ Other:

☐ Depressive disorder	☐ Hypothyroidism	
☐ Diabetes mellitus	☐ Inflammatory disease of liver	

Surgical History

Have you had any of the following surgeries?

☐ None	☐ History of bilateral mastectomy	☐ Pancreatectomy
Abdominoperineal resection	History of cholecystectomy	Kidney stone's
☐ Bilateral replacement of knee joints	☐ History of colectomy	☐ Portosystemic shunt operation
Biopsy of breast	History of liver excision	Prostatectomy
☐ Biopsy of prostate	☐ Percutaneous transluminal coronary angioplasty	☐ Prosthetic arthroplasty of bilateral hips
Coronary artery bypass graft	Tissue graft heart valve replacement History of total cystectomy	Splenectomy
☐ Entire transplanted kidney	☐ History of transurethral	☐ Surgical biopsy of skin
Excision of basal cell carcinoma	prostatectomy Hysterectomy	Total nephrectomy
☐ Excision of melanoma	☐ Kidney biopsy	☐ Total orchidectomy
Excision of squamous cell carcinoma		Total replacement of left hip joint
☐ H/O: colostomy	☐ Low anterior resection of rectum	☐ Total replacement of left knee joint
H/O: tubal ligation	Lumpectomy of breast	Total replacement of right hip joint Total replacement of right knee joint
☐ History of appendectomy	☐ Lumpectomy of left breast	☐ Transplantation of heart
History of bilateral mastectomy	Lumpectomy of right breast	Transplantation of liver
☐ History of cholecystectomy	☐ Mastectomy of left breast	☐ Other:
History of colectomy	Mastectomy of right breast	
☐ H/O: tubal ligation	☐ Mechanical heart valve replacement	

☐ History of appendectomy	Oophorectomy	

Podiatry Foot/Ankle Disease History

Select any of the following medical conditions you currently have:

☐ None	☐ Fracture of bone	☐ Peripheral venous insufficiency
Acquired cavus deformity of foot	Gangrenous disorder	Plantar fasciitis
☐ Acquired pes planus	☐ Hallux valgus	☐ Primary gout
Amputation	Laceration - injury	Recurrent falls
☐ Ankle ulcer	☐ Localized infection	☐ Rheumatoid arthritis
Bone tumor	Neoplasm of soft tissue	Rupture of Achilles tendon
☐ Chronic pain	☐ Neuroma of foot	☐ Sprain of lateral ligament of ankle joint
Deep venous thrombosis	Osteoarthritis	Ulcer of foot
☐ Dystrophia unguium	☐ Peripheral nerve disease	Other
Foreign body	Peripheral vascular disease	

Shoe Size:

Shoe Size: _____

Shoe Width:

- ☐ Narrow
- ☐ Medium
- ☐ Wide
- ☐ Extra Wide

Medications

List all current medications:

_____

_____

_____

Allergies

List all allergies:

_____

_____

_____

Social History

Smoking Status (please choose one):

- ☐ Current smokere
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking:_____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never

Family History

Please include only first-degree relatives:

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Musculoskeletal – Joint Pain		
Musculoskeletal – Joint Swelling		
Musculoskeletal – Joint Stiffness		
Musculoskeletal – Unsteady Gait		
Neurological - Numbness		
Neurological - Tingling		
Neurological - Dizziness		
Neurological - Headaches		
Neurological - Tremors		
Neurological - Fatigue		
Integumentary - Rash		
Integumentary - Itching		
Integumentary - Rash		
Integumentary – Scarring / Keloids		

Alerts

Pleasecheckyes or no for the following:

Symptom	Yes	No
Blood Thinners		
Pacemaker		
Defibrillator		
Allergic to Latex		
Allergic to Adhesive		
Under Pain Management		
Rheumatoid Arthritis		

Sims & Associates Podiatry

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payments for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered.
- You must inform the office of all insurance charges and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of them. In the event that it is, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. 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 this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

_____	_____	_____
Signature of Patient/Responsible Party	Print Name of Patient/Responsible Party	Date
_____	_____	_____
Signature of Witness	Print Name of Witness	Date

_____ Patient initials to indicate copy received

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Insurance Authorization & Assignment Form

All professional services rendered are charged to the patient. The necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of any insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance with our office.

If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

I hereby authorize Lewis J. Sims, DPM, PC to furnish any information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I UNDERSTAND THAT IF MY INSURANCE REQUIRES A REFERRAL, AND I DO NOT HAVE ONE, I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.

Insured Name (please print)	Signature	Date
Patient Name (please print)	Signature	Date

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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 so chose) and understood the notice.

_____ _____

Patient Signature Date

_____

Parent of Authorized Representative (if Applicable)