# PATIENT INFORMATION & HEALTH RECORD

In order to help us render the proper podiatric services to you, please complete this form in its entirety. We thank you for your cooperation.

DATE:_____ SOCIAL SEC. NO._____ DATE OF BIRTH_____SEX _____

NAME:_____ MARITAL STATUS_____ HOME PHONE_____

ADDRESS:_____ TOWN_____ STATE_____ ZIP_____

(If minor child, please state responsible party info.) NAME:_____

EMPLOYER:_____OCCUPATION_____

EMPLOYER ADDRESS:_____ TOWN_____STATE_____ ZIP_____

WORK PHONE NO:_____

SPOUSE'S NAME:_____DATE OF BIRTH:_____ WORK PHONE:_____

(Or if a child, parent's name responsible)

IN CASE OF EMERGENCY, CONTACT:_____NUMBER:_____

NEAREST FRIEND/RELATIVE:_____NUMBER:_____
(Not living with you)

FAMILY PHYSICIAN:_____NUMBER:_____

PHYSICIAN'S ADDRESS:_____

PATIENT'S CELL PHONE NUMBER: _____

PATIENT'S EMAIL ADDRESS: _____

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## INSURANCE INFORMATION

NAME OF CARD HOLDER:_____ Relationship to Patient:_____

NAME OF INSURANCE COMPANY:_____

INS. ADDRESS:_____ TOWN:_____ STATE:_____ ZIP_____

INS. PHONE:_____ CARD HOLDERS EMPLOYER:_____

POLICY NUMBER ON CARD:_____ GROUP NUMER IF ANY_____

(Including any prefixes…i.e., XWG, R, C without them your claim will be rejected by your ins. co.)

DATE OF BIRTH OF CARD HOLDER:_____

## SECONDARY INSURANCE INFORMATION

NAME OF CARDHOLDER:_____ Relationship to Patient:_____

NAME OF INSURANCE COMPANY:_____

INS. ADDRESS:_____ TOWN:_____ STATE:_____ ZIP_____

INS. PHONE:_____ CARD HOLDERS EMPLOYER:_____

POLICY NUMBER ON CARD:_____ GROUP NUMER IF ANY_____

DATE OF BIRTH OF CARD HOLDER:_____

Were you referred by (circle one): Your Physician Friend Yellow Pages Insurance Listing
(If by a friend, please give us the name. If by phone book or newspaper, let us know which one.)
Name of person or Ad source_____Other type not listed_____

DESCRIBE YOUR FOOT PROBLEM:_____

PREVIOUS FOOT SURGERY? YES NO

NAME OF DR. WHO PERFORMED SURGERY:_____DATE:_____

## HEALTH INFORMATION

HEIGHT:_____ WEIGHT:_____ AGE:_____

Please check off any of the following for which you have been or are being treated:

___Arthritis
___Rheumatic Fever
___Scarlet Fever
___High Blood Pressure
___Cardiac Disease
___Peripheral Vascular Disease
___Tuberculosis
___Gout
___Cerebral Accidents (Stroke)
___Diabetes
___Liver Disease (Hepatitis)
___Other – please state_____

___Epilepsy or History of Seizures
___Asthma
___Emphysema
___Glaucoma/Eye Problems
___Venereal Disease
___Bleeding Disorders
___Kidney Disease
___Polio, Cerebral Palsy, Muscular Dystrophy
___History of Blood Clots
___Anemia
___Thyroid
___HIV/AIDS

ALLERGIES: Are you allergic to any of the following? Please circle any that apply.

| | | | |
|---|---|---|---|
| Penicillin | Tetracycline | Aspirin | Sulfa Drugs |
| Novocain | Codeine | Barbiturates | Cortisone |
| Iodine Dyes | Adhesive Tape | Caffeine | Other_____ |

Are you taking any medications? Y N If so please provide a detailed list below.

_____ _____ _____ _____ _____

Are you currently under a doctor's care? Yes_____ No_____

Have you had previous surgery or hospitalization? Yes_____ No_____

(If yes, please provide us with approximate dates)_____

## OUR FINANCIAL POLICY

We are pleased that you have chosen us as your podiatric care provider. We are committed to your treatment being successful, and are certain you will be happy with the care provided by our staff. The following is a statement of our Financial Policy which we ask you to read and sign PRIOR to any treatment.

ALL patients must complete our Patient Information Record before being examined by the doctor.

## REGARDING INSURANCE

As a convenience to our patients, we submit claims to your insurance company on your behalf. WE CANNOT bill your insurance company UNLESS you bring in ALL insurance information (this may include claim forms and referrals). Patients who are in an HMO or POS program must present a referral prior to being seen by the doctor. Failure to do so will result in a rescheduling of the appointment. If you do not have a referral and you choose to be seen by the doctor, payment in full for that visit/treatment will be required at the time of visit.

We do require that all copays, deductibles, and services not covered by your insurance be paid at the time of service. (This may include post-operative supplies and medications considered "Over the Counter" items).

Your insurance policy is a contract between you and your insurance company. In the event that your insurance company has not paid your account within 45 days, the responsibility to pay the balance will automatically be transferred to you. Please be aware that some or all services provided by our doctors may not be covered and not considered reasonable or necessary under the Medicare Program and/or other insurance plans. Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. An interest charge of 1 ½% per month will be added to the unpaid balance of your bill that is 60 days or more overdue. You are legally responsible for any amount which is not paid by your insurance even if the physician is participating with your insurance plan. In the event that any amount due is unpaid, you are responsible for all costs of collection, including but not limited to a fee of 1/3 of the balance to cover collection fees, administrative fees, court costs, attorney fees and all other related expenses. I hereby agree to waive the defense of statute of limitations as it pertains to any claim filed against me beyond three years after services were rendered.

Again, we are billing your insurance company as a convenience to you. The insurance industry is changing everyday, we will make every effort to assist you, however, it is the patient's responsibility to know and be aware of his/her plan coverages, deductibles, copays, and limitations. If your insurance should change or if any information pertaining to yourself, your employer, and/or your dependents, please notify us as soon as possible to avoid delays in processing.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payments that your insurance company considers to be above the "usual and customary rate."

## MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If you are unable to keep an appointment, we require that you notify the office at least 24 hours in advance.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I have read the financial policy and authorize James Adleberg DPM, P.A. to apply for benefits on my behalf for services rendered by Dr. Adleberg. I request payment to be made directly to James Adleberg DPM, P.A. I certify the information given is true and correct to the best of my ability. I further authorize the release of necessary information, including medical information for this or any other related claim to my insurance company. I permit copy of this authorization to be used in the place of the original. I hereby give permission to Dr. Adleberg to examine and treat my feet and ankles as needed. I understand and acknowledge this statement.

_____ _____

Signature of the patient or responsible party Date

_____ _____

Co-responsible party Date