



NEUHAUS FOOT & ANKLE

Welcome To Our Office : Patient Information Sheet

Last Name: _____ **First:** _____ **MI:** _____

Mailing Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Ph #: (_____) _____ **Cell Ph #:** (_____) _____

Date of Birth: ____/____/____ **Social Security Number:** _____

Circle Gender: Male Female **Circle Marital Status:** Single Married Widowed Divorced

Employer: _____ **Work Phone #:(_____)** _____

Primary Care Physician: _____ **Phone #:** (_____) _____

How did you hear about our office? Circle: Website/Internet Doctor Insurance Co.
Yellow pages Friend Other _____

Name of Doctor and/or Friend that referred you: _____

Emergency Contact: _____ **Phone #:(_____)** _____

E-Mail Address: _____

Primary Insurance Company Information:

Policy Holder Last Name: _____

Policy Holder First Name: _____

Policy Holders SS# : _____ **Policy Holders Date of Birth:** ____/____/____

Gender:
 Male Female **Relationship to Policy Holder:**
 Self Spouse Child Other

Policy Holder's Address: Same as patient _____

City: _____ **State:** _____ **Zip:** _____

Insurance's Name: _____

Policy ID: _____ **Group #:** _____

Claim Submission Address: _____

Effective Date: ____/____/____ **Referral Required:** Yes No

Do you have a Co-pay? No Yes, Amt \$ _____

Secondary Insurance Company Information:

Policy Last Name: _____

Policy Holder First Name: _____

Policy Holders SS# : _____ **Policy Holders Date of Birth:** ____/____/____

Gender:
 Male Female **Relationship to Policy Holder:**
 Self Spouse Child Other

Policy Holder's Address: Same as patient _____

City: _____ **State:** _____ **Zip:** _____

Insurance's Name: _____

Policy ID: _____ **Group #:** _____

Claim Submission Address: _____

Effective Date: ____/____/____ **Referral Required:** Yes No

Do you have a Co-pay? No Yes, Amt \$ _____

Patient Signature (Parent or Guardian if patient under 18 years old)

Date

Patient Name: _____ **Date:** _____

Reason for your visit today: _____

When did problem start? _____

Previous treatment condition? Y N

Treatment by: _____ **Date treated:** _____

Check all treatments received for this condition:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Surgery | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Ice/Stretching | <input type="checkbox"/> Other: _____ |
-
-

► Vitals

Weight: _____ Height: _____

(Office Use ONLY: BP _____ P _____)

► Patient Medical History

Have you been diagnosed with any of the following? Please circle all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease (hepatitis) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers/Reflux |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Gout | | |

► Social History

Please answer the following:

- Occupation: _____
- Marital Status? Circle: Single Married Divorced Widowed
- Use of Alcohol? No Yes (If yes, how much?) _____
- Use of Tobacco? No Yes (If yes, how much?) _____
- Use of Drugs? No Yes (If yes, type/frequency) _____

► Allergies

None or List all known allergies:

► Family History

(Has anyone in your family been diagnosed with any of the following?)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |

► Current Medications

None or See Attached List

► Review of Systems

(Please check all conditions and symptoms that you currently have)

- | | | | | |
|-----------------|--|--|---|---|
| General | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| Eyes | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Glasses |
| Ear/Nose/Throat | <input type="checkbox"/> Ringing ears | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sore throat |
| Heart | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irreg. heart beat | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Feet swelling |
| Lungs | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other |
| Intestinal | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| Urinary | <input type="checkbox"/> Burning | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Other |
| Musculoskeletal | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Calf cramping |
| Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Sores/Ulcers | <input type="checkbox"/> Abnormal scar | <input type="checkbox"/> Varicose veins |
| Neurological | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling feet | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Tremor |
| Psychiatric | <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other |
| Endocrine | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other |
| Hematological | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Slow to heal |
| OB/GYN | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Menopausal |

► Previous Surgeries None or Please list procedure and date performed:

Patient Signature (Parent or Guardian if patient under 18 years old)

Date:



Financial Policy

- As a courtesy to our valued patients that have insurance plans, our office will file insurance claims for reimbursement for all rendered services. ***Actual benefit payments are determined only when the claim is processed by your insurance company. Therefore, it is the insurance company that makes the final determination of benefits. If the insurance payment does not fully reimburse for the treatment rendered, the financially responsible person is responsible for the remainder of the balance.***
- **Co-payments:** Your insurance company requires co-payments to be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for these.
- **Referrals:** If your insurance company requires a referral it is **YOUR** responsibility to obtain the referral. Failure to obtain the referral and/or prior authorization for treatment may result in a lower payment or denial from the insurance company.
- **Orthotics and Diabetic Shoes:** We require patients to obtain insurance verification before either can be ordered. We will provide you with an insurance verification form which will walk you through what is needed by the insurance company. If you do not have coverage for custom orthotics the cash price is \$300 per pair. We require a \$100 deposit at the time of the order and the remainder when you pick them up.
- There will be a \$25.00 fee charged for any returned checks (insufficient funds).
- **Worker Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.
- **Missed appointment Fee:** Any patient who does not show up for an appointment, or cancels with less than 24 hours notice will be subject to a \$25.00 charge after the 2nd occurrence. This fee must be paid before a new appointment is scheduled. Patients with **THREE** missed appointments will be asked to transfer their records to another doctor.
- **Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.
- **Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date on your statement. We are always willing to work out a payment plan if needed.
- **Past Due Accounts:** If necessary a collection agency will be employed to collect overdue accounts and the collection fee will be charged to the patient's account. Consequently, credit agencies will be notified of delinquent accounts. You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record and you consent to such disclosure.

Responsible Party Info:

Please complete **ONLY** if the responsible for payment is NOT the Patient or Insurance Policy holder

Responsible Party Name (Last/ First): _____

Relationship to patient: _____

Responsible Party Address: _____ **SS#:** _____

I, as the patient, financially responsible person and/or guardian for this account, certify that I have read, understood, and agreed to this financial policy.

Signature _____ Date _____ Patient's Name (printed) _____