AMH Podiatry
love your feet

Patient Information:

Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
_____ Marital Status: _____
Sex: ___ M ___ F Race: _____ Ethnicity: _____ Language Preferred: _____
Phone: _____ Cellular: _____
Email: _____ (For Appointment Reminders & Contact)

Employer: _____ Occupation: _____
Phone #: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____
Date Last Seen: _____ Who referred you here? _____

Pharmacy Preferred: _____ Phone: _____

Primary Insurance: (Please provide copies of the actual insurance cards)
Carrier: _____ Phone: _____
Member ID#: _____ Group: _____
Cardholders Name: _____ Date of Birth: _____Social Security#_____

Secondary Insurance:
Carrier: _____ Phone: _____
Member ID#: _____ Group: _____
Cardholders Name: _____ Date of Birth: _____Social Security#_____

Disclosure of Medical Information:
Your medical information and communication of that information is essential to your care. We prefer to speak directly with you, the patient, however we understand that other individuals may have knowledge and will be assisting you with your records and care. Please list those individuals with whom we may give medical information, make appointments or discuss medical matters with, in case you are unable to communicate with us.
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

Messages: Please give us authorization to return phone calls and leave medical information messages on any of the following answering machines or voicemails: (circle all that apply)

AT HOME WORK CELL PHONE EMAIL I do not authorize any of these

Medical Consent: **I consent to all treatment given under the general and special instructions of the attending physician(s). Treatment may include, but is not limited to, diagnostic procedure, administration of anesthetics, use of prescribed medication, medical and physical therapy services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary of advisable in the judgment of the attending physician or their designees.**

If a healthcare worker comes in direct contact with a patient's blood or bodily fluids, I understand that the patient's blood may be tested for Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency Virus) to determine whether or not the viruses are present, or endangering the health care worker. The results of the testing will be made available to the patient if this incident occurs.

Assignment of Insurance Benefits: I understand that I am responsible for any charges not covered by my insurance carrier. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect, and that I have the right to make this assignment. In the event a claim for payment submitted by AMH Podiatry to my insurance carrier or plan administrator is denied, I hereby authorize AMH Podiatry to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy.

Financial Agreement: I understand that, if my insurance plans or policy requires a co-payment from me, I am required to pay that co-payment at the time of service is rendered: I understand that , if a I am self- funded, full payment is due at the time of service. I understand that I am obligated to pay the patient account according to the regular rates and terms of AMH Podiatry. I appoint AMH Podiatry as my true and lawful attorney to collect the claims, endorse the checks, and give full and final receipt for all amounts collected on my behalf. In the processed accordingly, I understand that AMH Podiatry may obtain my credit report for review in collection of any debt. In the event that this account is placed with a collection agency or an attorney for collection, I understand that I will pay all collection fees and all reasonable attorneys' fees associated.

Disclosure of Health Information: I authorize AMH Podiatry to provide any health information related to my care to my insurance, to other insurance companies acting as other payers, to other physicians or healthcare facilities, or for operations such as peer reviews and outcome analysis's for the purposes of payment of the health care provided or for continued care. I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as a part of AMH Podiatry and may be enforced under the practice name or as AMH Podiatry.

Office Policies:

1. **If you need to reschedule your appointment, please call within 24 HOURS prior to appointment in order to avoid an in-office $ 25.00 non-cancellation fee.**
2. **All insurance COPAYS and applicable DEDUCTABLES are due at the time of service.**
3. **No credit card or debit charges under $25.00 allowed.**
4. **It is the patient's responsibility to update any insurance or changes in contact information in order to avoid any out of pocket expenses.**
5. **Please SIGN-IN upon arrival of your appointment.**
6. **If your insurance policy requires a referral to see a specialist, please have it at available at the time of your appointment.**
7. **Should you receive a payment from your insurance company for our service, you agree to release these payments to our office immediately.**
8. **If you are DIABETIC, please make sure to provide your primary care physicians name and contact information.**

I have acknowledged and agree to follow the policies and procedures of this office.

PRINT Patient Name or Patient Representative: _____

Signature of Patient or Representative: _____

Relation to Patient: _____ Date: _____

I acknowledge that I have received a copy of the AMH Podiatry Notice of Privacy Practices to review.
_____ Please initial

Patient: _____ Date of Birth: _____

Past Medical History:

How is your general health? Good Fair Poor

(Please circle any conditions you have been diagnosed with)
Cardio: Congestive Heart Failure High Blood Pressure Deep Vein Thrombosis (DVT) Stoke
Other:_____
Respiratory: Asthma COPD Emphysema Lung Cancer Pneumonia Tuberculosis
Other:_____
Dermatological: Cellulitis STD Psoriasis Warts Other: _____
Endocrine: Insulin Dependent Diabetes Non-Insulin Dependent Diabetes Hypothyroid Hyperthyroid
Other:_____
GI/GU: Ulcers GERD Chrohn's Disease Liver Condition Stomach/ Bowel Kidney Disease
Other:_____
Hematological: Anemia Lymphoma Leukemia Bleeding Abnormalities Other: _____
Neurological: Alzheimer's Migraines Neuropathy Seizures Sciatica Other: _____
Psychiatric: Depression Dementia Alcoholism Drug Abuse Other: _____
Musculoskeletal: Arthritis Gout Osteoporosis Fibromyalgia Amputation Bone Infections
Other:_____

Hospitalizations or Surgeries:_____

_____

_____

_____

Medication Allergies: Have you ever had a reaction to a medication? Yes No
Please circle or list: Aspirin Sulfa Penicillin Codeine Tape Latex Other: _____

Medications: _____ NONE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Please circle) Alcoholism Arthritis Cancer Bleeding Disorder Heart Problems
Seizures Stroke High Blood Pressure Other: _____

Social History: Do you Use Tobacco? Yes/ No How much? _____ How long? _____
Drink Alcohol? Yes/ No How much? _____ How long? _____
Use Illicit Drugs? Yes/ No Please list_____ Often?_____

Do you exercise or participate in Athletic Activities on a regular basis? Yes No
Please list: _____ How Often? _____

Chief Complaint:

Primary reason for visit today: _____New patient _____Follow/Up

Primary foot or ankle problem involves: _____Left _____Right _____Both

How long has this troubled you? _____ Weeks _____Months _____Years

Have you had previous care by a physician or other podiatrist for this problem? _____Yes _____No
If yes, please explain treatment: _____
_____
_____

Have you had any X Rays or MRI? _____Yes _____No If yes, Where? _____

Your present Weight? _____Lbs. Height? _____ Shoe Size :_____

Review of Systems: (Please circle any current or recent symptoms)
General: Weight Changes Change in Health Change in Strength
Head: Headaches Dizziness Head Trauma
Ears: Change in Hearing Ringing in Ears Ear Bleeding
Eyes: Change in Vision Glaucoma Wears Glasses
Nose: Bleeds Head Cold/ Drainage Obstruction of Nose
Mouth: Dentures Loose Teeth Gum/ Gingival Disease
Neck: Stiffness Pain/ tenderness Mass
Breast: Lumps Tenderness Swelling Nipple Discharge
Chest: Difficulty Breathing Wheezing Bloody Sputum Coughing
Heart: Chest Pains Heart Palpitations Fainting
Abdomen: Change in Appetite Difficulty Swallowing Abdominal Pains Bowel Change Vomiting
Urinary: Urgency Painful Urination
Musculoskeletal: Joint Pain Limited Range of Motion Numbness
Neurological: Weakness Tumors Seizures Loss of coordination
Psychiatric: Depressive Symptoms Change in Sleep Habits

Any additional Information you feel is important for your visit:_____
_____
_____

I agree that the information provided is true and correct to the best of my knowledge.

PRINT Patient Name or Patient Representative :_____

Signature of Patient or Representative:_____

Relation to Patient: _____ Date: _____