NEW CASTLE ASSOCIATES IN PODIATRY *Today's Date:* _____

Thank you for choosing our office! Due to new healthcare regulations and in order to serve you properly, ALL of the following information MUST be completed. All information will be kept confidential. PLEASE PRINT.

Patient Name: _____ AKA: _____
Address: _____ City: _____ State: _____ Zip Code: _____
DOB: ___/___/___ SSN: _____ If patient a minor, parent/guardian name(s): _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____
Email: _____ Preferred Communication: Home___ Cell___ Work___ Email___
Preferred language if not English: _____

Gender: M____ F____ Race: _____ Ethnicity: Hispanic_____ Non-Hispanic_____
Marital Status: Single____ Married____ Life Partner____ Divorced____ Separated____ Widowed____

Pharmacy: _____ Location: _____ Phone #: _____
Family Physician: _____ Phone #: _____
Specialists: _____

Name & Relationship of person we may speak with regarding your medical history: _____
Emergency Contact & Relationship: _____ Phone #: _____
Whom may we thank for referring you: _____

RESPONSIBLE PARTY (MUST BE COMPLETED FULLY IF OTHER THAN PATIENT)
Name of person responsible: _____ Relationship to patient: _____
Address (if different from above): _____
Home #: _____ Cell #: _____ Work #: _____ Ext: _____
DOB: _____ Employer: _____

MEDICARE AUTHORIZATION (Medicare patients read & sign)
I request that payment of authorized Medicare benefits be made either to me or on my behalf to New Castle Associates in Podiatry, for any services furnished me. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE: _____ DATE: _____

ASSIGNMENT AND RELEASE (All other insurances)
I, the undersigned certify that I (or my dependent) have the insurance coverage that was provided to New Castle Associates in Podiatry and assign directly to them, all insurance benefits, if any, otherwise payable to me for services rendered.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

NEW CASTLE ASSOCIATES IN PODIATRY

Patient Name: _____ DOB: _____
(PLEASE PRINT)

FOOT/ANKLE HISTORY:

What problem(s) are we seeing you for today? _____
Have you ever been to a Podiatrist before? Yes_____ No_____
If yes, name & last visit: _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

ALLERGIES-PLEASE CHECK ALL THAT APPLY AND LIST REACTION:

Adhesive/Tape_____ Aspirin_____ Codeine_____ Iodine_____ Penicillin_____ Sulfa_____ Seafood_____
Local Anesthetics_____ Other_____
REACTION(S): _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____
_____
_____

MEDICAL INFORMATION-PLEASE CHECK ALL THAT APPLY:

AIDS/HIV_____ ADD/ADHD_____ Anemia_____ Angina_____ Arthritis_____ Artificial Heart Valves or Joints____
Asthma_____ Back Problems_____ Bleeding Disorders_____ Cancer(please be specific)_____
Circulatory Problems_____ Diabetes_____ Epilepsy_____ GI Disease_____ Glaucoma_____ Gout_____
Headaches_____ Heart Disease_____ Hepatitis_____ High Cholesterol_____ Hypertension_____ Kidney Disease____
Liver Disease_____ Osteoporosis_____ Phlebitis_____ Respiratory Disease_____ Stroke_____ Substance Abuse_____
Thyroid Disease_____ Ulcers_____ Other_____

PLEASE LIST WITH DATES ANY MAJOR OPERATIONS OR ILLNESS:

_____
_____
_____

FAMILY HISTORY-PLEASE CHECK ALL THAT APPLY:

AIDS/HIV_____ ADD/ADHD_____ Anemia_____ Angina_____ Arthritis_____ Artificial Heart Valves or Joints____
Asthma_____ Back Problems_____ Bleeding Disorders_____ Cancer(please be specific)_____
Circulatory Problems_____ Diabetes_____ Epilepsy_____ GI Disease_____ Glaucoma_____ Gout_____
Headaches_____ Heart Disease_____ Hepatitis_____ High Cholesterol_____ Hypertension_____ Kidney Disease____
Liver Disease_____ Osteoporosis_____ Phlebitis_____ Respiratory Disease_____ Stroke_____ Substance Abuse_____
Thyroid Disease_____ Ulcers_____ Other_____

NEW CASTLE ASSOCIATES IN PODIATRY

Patient Name: _____ DOB: _____
(PLEASE PRINT)

SOCIAL HISTORY-PLEASE CHECK ALL THAT APPLY:

Alcohol: Yes____ No____ If yes, Beer____ Wine____ Liquor____
Frequency: Daily____ Weekly____ Social____ 1 Drink____ 2-3 Drinks____ 3 or more drinks_____
Children: Yes____ No____ If yes, how many and ages:_____
Coffee Use: Yes____ No____ If yes, how many cups per day?_____
Exercise: Aerobics____ Martial Arts____ Yoga____ Running____ Walking____ Pilates____ EFX____ Cycling____
Swimming____ NONE____
Sports: Baseball___ Basketball___ Field Hockey___ Football___ Golf___ Lacrosse___ Soccer___ Volleyball___ Weights___
Frequency: Daily___ 1x week___ 2x week___ 3x week___ 4x week___ 5x week___ 6x week___ 7x week___
Duration: 15-30 minutes____ 30-60 minutes____ More than 60 minutes____
Occupation: _____ Employer: _____
If patient is a student, grade & name of school: _____
Smoke: Yes____ No____ If yes, Cigarettes____ Pipe____ Cigar____ Chewing Tobacco____
Frequency: Daily____ Weekly____ Occasional____ Social____
Amount: 1 pack____ 2 packs____ 3 packs____ 4 packs or more____ Other_____
Smoking history: Yes____ No____ When did you quit?_____ How many years did you smoke?_____

REVIEW OF SYSTEMS:

EYES: Double Vision____ Glaucoma____ Cataracts____ Vision Loss____
EARS, NOSE, MOUTH, THROAT: Ringing in Ears____ Dizziness____ Hearing Loss____ Nose Bleeds____
Sinus Trouble____ Bleeding Gums____ Hoarseness____
CARDIOVASCULAR: Murmur____ Chest Pain____ Shortness of Breath____ Leg Pain____
RESPIRATORY: Cough____ Pain with Breathing____
GASTROINTESTINAL: Trouble Swallowing____ Nausea____ Vomiting____ Diarrhea____ Constipation____
Blood in Stools____ Abdominal Pain____
URINATION: Frequent____ Painful____ Bloody____ Incontinence____
MUSULOSKELETAL: Muscle or Joint Pain____ Arthritis____
SKIN: Rash____ Sores____ Itching____
PSYCHIATRIC: Depression____ Anxiety____ History of Psychiatric Problems____
ENDOCRINE: Thyroid Trouble____ Heat or Cold Intolerance____ Thirsty or Hungry____
HEMATOLOGICAL: Anemia____ Swollen Glands____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY FOOT CONDITION.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:

_____
(DATE)

ONLY COMPLETE IF OVER THE AGE OF 60

PAD Assessment (Peripheral Artery Disease)

TODAY'S DATE

FIRST NAME LAST NAME DATE OF BIRTH

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

Circle YES or NO on the following questions and check all boxes that apply:

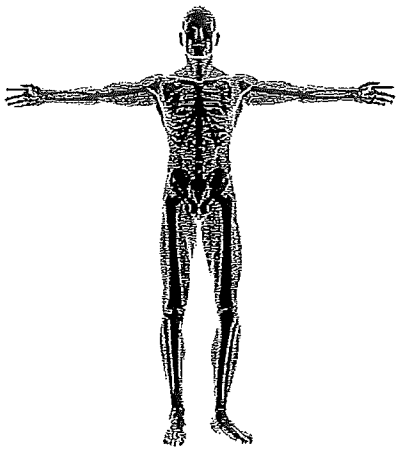
1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? **YES NO**

2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? **YES NO**
If yes, dates:_____

3 When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks? **YES NO**

4 If you answered Yes to #3, when do you feel the pain:
- ☐ After walking 1 block
- ☐ Climbing a flight of stairs
- ☐ After walking 100 yards
- ☐ Walking at increased speed

5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.



6 If you have pain, does the pain subside with rest? **YES NO**

7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? **YES NO**

8 Do you have any painful sores or ulcers on legs or feet that do not heal? **YES NO**

9 Are your legs discolored or bluish? **YES NO**

10 Check all that apply:
- ☐ I am a current smoker
- ☐ I have a history of smoking
- ☐ I have diabetes
- ☐ I have a family history of diabetes
- ☐ I have high cholesterol
- ☐ I have a family history of high cholesterol
- ☐ I have high blood pressure/hypertension
- ☐ I have a family history of high blood pressure/ hypertension
- ☐ I have/had coronary artery disease (CAD)/heart attack
- ☐ I have a family history of coronary artery disease (CAD) /heart attack
- ☐ I have had a stroke/mini-stroke/TIA
- ☐ I have a family history of stroke/mini-stroke/TIA

New Castle Associates in Podiatry

ACKNOWLEDGEMENT OF RECEIPT OF SEPTEMBER 23, 2013 NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices of: **New Castle Associates in Podiatry**

_____ _____

Signature Print Name

DATED: _____

OFFICE USE ONLY

Date acknowledgement received : _____

Date and reason acknowledgement was not obtained:

_____

_____

_____

_____

BY: _____

Signature

New Castle Associates in Podiatry
Patient Payment Policy

Referrals and Pre-Authorizations
If your insurance policy requires that you obtain a referral or Pre-authorization from your Primary care physician, it is your responsibility to ensure this is received prior to any treatment or services. In the event we do not receive a referral or Pre-authorization, we will need to reschedule your appointment until the information is received. You will be responsible for any charges incurred if we were not made aware from you that a referral was required. It is the patients responsibility to understand what services and requirements are within your insurance policy.

Payment Options
New Castle Associates in Podiatry accepts the following payment options:

Cash Checks VISA MasterCard Debit Card

All deductibles, and co-pays are due at the time of your visit. We will submit your claim to your insurance company (if applicable) for payment. Any balance that is determined to be your responsibility must be paid in full immediately.

Any check that is provided to us for Insufficient funds or bad information, will incur a $25.00 charge to your account. You will be required to contact us immediately and make payment on your entire balance within 10 days of receiving notification from us.

In the event your account is referred to a collection agency for lack of payment, your account will be charged a surcharge of up to 37% of your current balance to service your account for payment. We understand that unexpected circumstances can arise that could cause you to experience financial hardship. In the event this occurs, please contact our office so arrangements can be made to keep your account from going delinquent. Our qualified billing associates may be able to make payment arrangements for you in the event this occurs. We make every effort to discuss your account with you prior to sending it to a collection agency.

Missed/ No-Show Appointments
In order to ensure we always provide the highest level of care to our patients, it is critical that we receive sufficient notification when you need to cancel your appointment. We request that you notify us within 24 hours of your appointment date. In the event you do not meet this requirement or do not show up for a scheduled appointment, a $25.00 fee will be charged to your account.

By signing this form, I acknowledge the information above and agree to the terms and conditions.

Patient Name (please print) _____

Patient Signature: _____ Date _____