PATIENT BACKGROUND

PATIENT'S NAME _____
LAST FIRST MIDDLE SPOUSE/PARENT

A**DDRESS** _____**PHONE:** _____ **CELL:**_____

AGE _____ **DATE OF BIRTH** _____ **SEX** _____ **MARITAL STATUS** _____**SOC. SEC. NO.** _____
Last 4 digits

Guardian's name if patient is a minor _____

Guardian's address if different from above _____

PHARMACY NAME, LOCATION AND PHONE NO. _____

_____

_____
OCCUPATION **EMPLOYER** **BUSINESS ADDRESS** **PHONE NO.**

_____
OCCUPATION OF SPOUSE OR PARENT **EMPLOYER** **BUSINESS ADDRESS** **PHONE NO.**

PERSON RESPONSIBLE FOR BILL _____
NAME ADDRESS PHONE NO.

IN CASE OF EMERGENCY, CONTACT _____PHONE NO. _____

HEALTH INSURANCE CARRIER(S), ID NO. _____

Please tell us, as well as you can, the main problem, as well as other problems, that bring you to our office for help

_____

Have you ever been to a podiatrist?_____ **HEIGHT** _____ **WEIGHT** _____ **SHOE SIZE** _____

Please answer the following questions related to your general health so we may better know you and your medical background. The feet reflect systemic problems, and conversely, often the feet reflect bodily functions.

I am allergic to (please check)

( ) Aspirin	( ) Iodine	( ) Penicillin	( ) Other _____
( ) Codeine	( ) Latex	( ) Sulfa	_____
( ) Demerol	( ) Novocain	( ) Tape	( ) Nothing that I am aware of

Are you in ( ) good health ( ) fair health ( ) poor health

Tobacco use: Never _____ Current/packs a day _____ Quit Date _____

Physician's **NAME AND ADDRESS** _____

Are you under the care of a doctor? _____ If yes, please state problem _____

What medications are you now taking? _____
Do you, or have you ever had, any of the following?

( ) Anemia	( ) Diabetes	( ) Heart Trouble	( ) Rheumatism ( ) Tumors
( ) Arthritis	( ) Epilepsy	( ) High Blood Pressure	( ) Scarlet Fever
( ) Asthma	( ) Glaucoma	( ) Kidney/Bladder Trouble	( ) Stomach Ulcers
( ) Bleeding Tendencies	( ) Gout	( ) Nervousness	( ) Stroke
( ) Cancer	( ) Heart Murmur	( ) Rheumatic Fever	( ) Tuberculosis

SURGERIES: _____

_____

Westside Podiatry Group, LLC

fellows American College of Foot and Ankle Surgeons
diplomates American Board of Podiatric Surgery

OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

1. Full payment is expected at the time of service unless other arrangements are made. There will be an additional charge of $10.00 for copayments not made at the time of the visit.

2. A service charge of $5.00 per month on the unpaid balance will be charged after 30 days.

3. If an appointment is broken and not canceled, a charge of $48.00 will be applied to your account.

4. Returned checks are subject to a $20.00 service charge and will terminate your privilege to pay by check in the future.

5. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, that the patient will be fully responsible for any costs, including, but not limited to attorney's fees.

RELEASE OF INFORMATION AND HIPAA SIGNATURE:

I hereby authorize Westside Podiatry Group to release all information regarding services rendered to my insurance company/Medicare, keep my signature on file, and to accept third-party payments from my insurance company. However, I agree to take financial responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

I acknowledge that I have had the opportunity to read the Privacy Practice Act located in the reception area, and I understand the notice.

Please sign below to indicate you have read the above Office Financial Policy section and the Release of Information and HIPAA section and understand them fully.

_____ _____

Print Name Date

_____

Signature

GREECE OFFICE
2236 RIDGE ROAD WEST
ROCHESTER, N.Y. 14626
(585) 225-2290
FAX (585) 225-1367

GATES-CHILI OFFICE
507 BEAHAN ROAD
ROCHESTER, N.Y. 14624
(585) 247-2170
FAX (585) 247-3614

BRIGHTON OFFICE
919 WESTFALL ROAD
BUILDING C, SUITE 130
ROCHESTER, N.Y. 14618
(585) 506-9790
FAX (585) 697-0116

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PATIENT PRIVACY AUTHORIZATION

1. Please list any family members or other person(s), if any, whom we may inform about your general condition and your diagnosis:

   _____

   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition in an emergency (if different from above).

   _____

   _____

3. May confidential messages (i.e. lab reports, X-ray results, appointments, etc) be left on your [ ] home answering machine, [ ] voicemail or [ ] with family members? Please check all for which you grant consent.

4. May we call you at work? [ ] Yes [ ] No

5. If necessary, may we fax your protected health information to another doctor's office, insurance company, employer, pharmacy, school, attorney, town offices (handicap parking), nursing/resident home? [ ] Yes [ ] No. Please be advised that checking "No" may lead to significant delays in important communications regarding your health care.

6. Please list any other pertinent information you think this office should know regarding your privacy.

   _____

   _____

7. I am aware that a cellular phone is not a secure phone line.

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Print Name	Signature	Date

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