Practice: **Today's Date:**

Name: ____________________ **DOB:** __________ **Chart Number:** __________

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** __________

E-mail: ____________________ **Spouse/Partner Name:** __________

E-mail newsletters, reminders, statements, etc. **Emergency Name:** __________ **Phone:** __________

Address: ____________________ **City:** __________ **State:** ______ **Zip:** ______

Home #: __________ **Cell #:** __________ **Other #:** __________

Employer: ____________________ **Phone:** __________

Employer Address: ____________________ **City:** __________ **State:** ______ **Zip:** ______

Primary Insurance: ____________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: __________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: __________ Sex: ☐Male ☐Female DOB: ___/___/___

Address: ____________________

Policy ID: __________ Group ID: __________ Employer: __________

Secondary Insurance: ____________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: __________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: __________ Sex: ☐Male ☐Female DOB: ___/___/___

Address: ____________________

Policy ID: __________ Group ID: __________ Employer: __________

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: __________

What is the reason for your visit today? ____________________

____________________ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? ____________________

____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: __________

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____________________ Date: __________

Rev 1/21/2015

Practice: **Today's Date:**

Name: ______________________ **Chart #:** __________ **Date of birth:** __________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: ______________________ ☐Declined to specify

Pharmacy Name: ______________________ **Pharmacy Phone:** __________

Pharmacy Address: ______________________ City, State, Zip: __________

Primary Care Physician: ______________ Phone: __________ Date Last Seen: __________

Address: ______________________

Referring Physician: ______________ Phone: __________ Date Last Seen: __________

Address: ______________________

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: ______________________

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other:

Name(s): ______________________

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: ________ / ________

Height: __________ Weight: __________

Current Medications

☐No Known Medications ☐I take the following medications:

Name: ______________________

Name: ______________________

Name: ______________________

Name: ______________________

Name: ______________________

Name: ______________________

Name: ______________________

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: __________ Reaction __________

Name: __________ Reaction __________

Name: __________ Reaction __________

Name: __________ Reaction __________

Name: __________ Reaction __________

Name: __________ Reaction __________

Name: __________ Reaction __________

Use the back of this form if more room is needed

Last Flu Shot Date: ______________ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Have you completed any Advanced Directives? ☐Yes ☐No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: ______________________ Date: __________

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History and Physical

Name: ____________________ **DOB:** __________ **Chart Number:** __________

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* __________ ☐ Thyroid disease *(specify)* __________ ☐ Diabetes (type 1, type 2) ☐ CVA
☐ Arthritis *(specify)* __________ ☐ other *(specify)* __________ ☐ HIV ☐ Stroke
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: ____________________
Do you have any artificial joints? ☐ Yes (where? __________) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: __________
☐ Yes, I had a past substance abuse problem. Please specify: __________
☐ No, I have never had a substance abuse problem
What is your occupation? ____________________ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: __________
____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	__________	☐ Depression	__________
☐ Arthritis	__________	☐ Diabetes	__________
☐ Bleeding disorders	__________	☐ Emphysema	__________
☐ Blood clot	__________	☐ Heart disease	__________
☐ Cancer	__________	☐ High Blood Pressure	__________
☐ Cataracts	__________	☐ Neurological	__________
☐ Circulation problems	__________	☐ Strokes	__________
☐ Other (specify):	__________		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

System	Symptoms
Cardiovascular	☐ leg pain when walking ☐ fever ☐ chest pain/pressure ☐ leg swelling ☐ cold hands/feet ☐ fainting ☐ palpitations ☐ vascular disease ☐ valve problems ☐ **NONE**
Genitourinary	☐ blood in urine ☐ hesitancy ☐ incontinence ☐ increased urgency ☐ decreased frequency ☐ excessive urination ☐ kidney disease ☐ kidney stones ☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ heartburn ☐ blood in stool ☐ vomiting ☐ ulcers ☐ constipation ☐ diarrhea ☐ trouble swallowing ☐ decrease appetite ☐ increase appetite ☐ **NONE**
Integumentary	☐ athletes foot ☐ nail abnormalities ☐ keloids ☐ itchiness ☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers ☐ sickle cell disease ☐ anemia ☐ blood thinners ☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling ☐ weakness ☐ seizures ☐ numbness ☐ headaches ☐ tremors ☐ paralysis ☐ **NONE**
Musculoskeletal	☐ back pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ neck pain ☐ sciatica ☐ joint stiffness ☐ joint pain ☐ joint instability ☐ arthritis ☐ **NONE**
Respiratory	☐ chest pain ☐ wheezing ☐ COPD ☐ coughing ☐ snoring ☐ shortness of breath ☐ emphysema ☐ **NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____________________ Date: __________

Financial Policy For Dr. Theodore A. D'Amato D.P.M

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you Are insured by a plan we participate with but do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or Other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist, that you Must have a referral from your primary care doctor prior to making an appointment. Therefore you are financially responsible for services rendered unless your referral is presented at time of this visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to 3 notices for your financial responsibility (co-ins, deductibles) after payment and/or EOB is received from your insurance company(s). After 3rd and last notice, your account will be forwarded to collections. Payment arrangements can be made on a case by case basis. If you are on a payment plan and skip a month's payment then the remaining balance will be sent to collections. We accept the following payment methods: Cash, Check or Credit card. Any returned checks will have a $40 fee per check returned. In the event that your insurance company should happen to send you the payment, we expect that you would forward it to our office to be applied to your balance.

DEDUCTIBLES OR A PORTION MUST BE PAID AT TIME OF VISIT

****20% LATE CHARGED APPLIED EACH MONTH FOR OUTSTANDING BILLS****

*****$75 FEE FOR MISSING OR NOT GIVING 24 HOURS NOTICE TO CANCEL/RESCHEDULE APPOINTMENT*****

******40% SURCHARGE FOR ANY ACCOUNTS SENT TO COLLECTIONS******

*******IF YOU ARE MORE THAN 10 MIN LATE FOR YOUR APPOINTMENT YOU WILL HAVE TO RESCHEDULE*******

I have read the above policy regarding my financial responsibility to Dr. Theodore A. D’Amato DPM for medical services provided. I agree to pay Dr D’Amato any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent)have coverage with my insurance as presented and assign directly to Dr D’Amato all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of deductibles,co-pays,co-ins and /or non covered services. I hereby authorize the Dr. to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to any insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions

PRINT PATIENT NAME:________________________ **SIGNATURE:**_________________________

FINANCIALLY RESPONSIBLE PARTY:

PRINT NAME: _______________________ **SIGNATURE:**_________________________