PATIENT RECORD (2009) TODAYS DATE__________________

Account #__________ **Please fill out completely** Location: PG 1

Dr. Michael J Petrocelli

Patients full name:

Last______________________First__________________________MI_________ Sex M F

Patient SS #____________________________ Date of Birth______________________

Marital Status S M D W Name of Spouse ______________________________________

Phone____________________Work____________________Cel ________________________

Local Address____

City__________________State__________Zip___________

Second or out of state Address____

City________________State_______________Zip___________

Pharmacy # _________________________ E-Mail ____________________________________

Employer Name ___________________ Job Title ______________________________________

Company Phone __________________ Address ______________________________________

____

How did you hear about us?_________________ If referred, by whom?_____________________

Name and relationship of Emergency Contact ______________________________________

Phone number of Emergency Contact ____

Name of Family Physician__________________________ Date last seen: __________________

Phone______________________________ Fax______________________________________

Address____

____ ____________________________

SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name____ SS#________________________

Address____

Phone_____________________________ DOB ________________________________

Please describe what brings you to the office today?

____

____

How would you describe your pain?

Sharp aching throbbing Shooting
electrical sensation pins and needles burning

Location of pain or primary complaint:

lower leg ankle Achilles tendon heel midfoot arch forefoot
sole of foot ball of foot top of foot big toe lesser toes toenails

How long has your problems been present?

1 – 3 days 3 – 7 days 1 – 3 weeks 3 – 6 weeks 6 – 8 weeks
3 – 6 months 6 – 9 months 9 – 12 months greater than 1 year

Onset of condition or injury:

gradual onset over time sudden onset from activity or injury

Course/progression of condition:

severe worsening moderate worsening mild worsening steady / unchanging
mild improvement moderate improvement considerable/good improvement

Pain / condition aggravated by:

any weight bearing standing walking running exercise bending
stooping pressure to ball of foot pressure from shoes pressure from jumping

Have you attempted any treatments to relieve your problem?

rest ice elevation change shoe gear over the counter padding
over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)
in home whirlpool stretching trimming out toenail yourself applying skin cream
applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, ext)

How much improvement and relief have you achieved with previous treatments?

mild improvement moderate improvement considerable improvement
no improvement worsening of condition

What is your activity level at work:

sitting standing walking considerable movement/walking retired

Name of Primary Care / Family Physician (first and last name) ?

____

Date last seen by Primary Care / Family Physician (month, day and year if known)

How did you hear about our office ?

physician family/friend internet newspaper

phone book advertisement other ______________________

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI insulin dependent diabetes

non insulin dependent diabetes stroke/CVA aneurysm blood clot

Do you have:

fatigue nausea chills

weight loss greater than 10 pounds weight gain greater than 10 pounds

Eyes - Do you have:

impaired vision cataracts glaucoma

macular degeneration frequent eye infections

Ears - Do you have:

hearing loss frequent ear infections

dizziness loss of balance

Nose - Do you have:

sinus problems/Allergies frequent nose bleeds difficulty breathing

nasal polyps deviated septum

Throat - Do you have:

frequent throat infections hoarseness

difficulties with speech frequent swollen nodes/glands in neck

Respiratory - Do you have:

asthma bronchitis emphysema shortness of breath tuberculosis valley fever
lung cancer collapsed lung/atelectasis pneumonia

Cardiovascular - Do you have:

Hypertension/high blood pressure Myocardial Infarct/Heart attack chest pain angina
palpitations/irregular beats valve prolapse/heart murmur rheumatic fever
angioplasty open heart/bypass surgery pacemaker congestive heart failure

Vascular/Circulation - Do you have?

circulation disorder/decrease leg pain at rest leg pain with walking atherosclerosis/blocked arteries
high cholesterol phlebitis blood clot/deep vein thrombosis varicose veins

Gastrointestinal - Do you have:

reflux/heart burn ulcer abdominal pain gallbladder problems liver disorder
hepatitis A hepatitis B hepatitis C
excessive hunger excessive thirst loss of appetite colitis

Genitourinary - Do you have:

frequent bladder/urinary tract infections kidney stone frequent urination/incontinence
renal failure renal dialysis Ovarian cancer (female only) Prostate cancer (male only)

Genitourinary - Have you had any of the following Sexually Transmitted Diseases?

gonorrhea syphilis Chlamydia herpes HIV

Hematological -Do you have:

Anemia sickle cell disease or trait cancer/leukemia blood transfusion

Hematological - Have you been anticoagulant with any of the following blood thinners?

Coumadin Heparin Aspirin Plavix

Endocrine - Do you have:

Diabetes
Thyroid disease

Neurological - Do you have:

seizures stroke tremor change in memory frequent head aches frequent head aches
polio muscle weakness neuro-muscular disease numbness sciatica

Musculoskeletal - Do you have:

Arthritis/degenerative joint disease rheumatoid arthritis gout back pain
hip pain knee pain frequent muscle/tendon pain

Musculoskeletal - Do you have any of the following joint replacements/prosthesis:

hip knee ankle
hands feet spine

Date of joint replacement:

____

Integument - Do you have:

skin rashes psoriasis eczema skin cancer hives skin growth
color change to mole or wart change in size of skin growth itching to skin thick scar/keloid

Psychiatric - Do you have:

depression nervousness anxious/OCD phobias bipolar disease memory loss
concentration difficulties/ADHD feelings of worthlessness/low self esteem suicidal schizophrenia/psychosis

Immunology - Do you have:

HIV Frequent infections/weak immune system chronic fatigue syndrome/Ebstein Barr

Past medical history – injuries/trauma

______________________ ______________________

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

____

Past Surgical History: Have you had any of the following surgeries?

heart bypass	heart valve repair/replacement	appendectomy
gallbladder	brain surgery	other

Please list approximate month and year of any surgery listed above:

____

Any other surgeries? (Please specify type of surgery and date)

____

Any complications/problems with surgery or anesthetics? (please specify)

____

Previous hospitalization - have you been admitted for:

heart attack	stroke	pneumonia	cancer
infection	injury	other hospitalizations	

Please list approximate month and year of any hospitalization listed above:

____

Childhood History - Do you ever had:

rheumatic fever	measles	mumps	chickenpox	herpes/cold sores

Childhood Immunizations – have you been immunized for:

measles	mumps	rubella	diphtheria	tetanus
varicella zoster	polio	tuberculosis	pneumonia	flu

Family History - Father - Does/Did your father have:

Hypertension/high blood pressure	CVA/stroke	Diabetes
cancer	circulation problems	

Any other illnesses? (please list) ______________________________

Is your father deceased? yes no

If your father is deceased - age and cause of death______________________________

Family History - Mother - Does/did your Mother have:

Hypertension/high blood pressure   CVA/stroke   cancer

circulation problems   Diabetes

Any other illnesses? (please list) ______________________________

Is your mother deceased?   yes   no

If your mother is deceased - age and cause of death______________________________

Family History Siblings - Does/Did your siblings have:

Hypertension/high blood pressure   CVA/stroke   cancer

circulation problems   Diabetes

Any other illnesses? (please list) ______________________________

Current Occupation: ______________________________

Marital status/ Living arrangement:

married   single   widowed   divorced   other

Social History - Do you:

smoke tobacco   smoke marijuana   use hallucinogenic drugs

drink alcohol   use cocaine   use other recreational drugs

Number of drinks per day?

1   2   3   4   5   greater than 5 per day   1 – 3/week   4 – 6 /week

Occasional use only   social drinking only   weekend drinking only

If you smoke, number of packs per day?

1/2   1   2   3   4   5 or more

1 -2/week   3 – 4/week   occasional   social   weekends

If you use other recreational drugs - please list/specify:

____

Women - Are you pregnant?

yes no

If pregnant, number of months:

____

Education:

did not complete high school | complete high school | some college | completed college

some grad school | masters degree | doctorate degree

Medications - please list medications (including aspirin) currently taking:

____

____

____

Allergies - Do you have allergies to any of the following:

drug allergies | penicillin | sulfa | erythromycin

aspirin | cortisone | codeine | adhesive tape

local anesthetics | **no known allergies**

Other allergies to medications - please list:

____

Do you have any **food** allergies - if so, please list:

____

Do you have any allergies to **plants** - if so, please list:

____

What is your height? ___________ **What is your weight?** ___________ **What is your Shoe size?** ___________

Vitals – What is your Pulse rate per minute? (only if you know your average value – otherwise leave blank)

Vitals – What is your Respiratory rate per minute? (only if you know your average value – otherwise leave blank)

Vitals – What is your Temperature ? (only if you know your average value – otherwise leave blank)

Vitals – What is your Systolic Blood Pressure? (only if you know your average value – otherwise leave blank)

Vitals – What is your Diastolic Blood Pressure ? (only if you know your average value – otherwise leave blank)

COLLIER PODIATRY, P.A.

INSURANCE INFORMATION

☐ I have no insurance. ☐ I have insurance. ☐ I have Medicare.

Your Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Name: ______________________________ D.O.B.______________

Primary Insurance: ____

Secondary Insurance: ____

● Please give the receptionist your insurance cards and driver's license ●

– – – – – – – – – – – – – – – – –**MEDICAL RELEASE**– – – – – – – – – – – – – – – – –

I consent to diagnosis and treatment of my medical condition (or of a minor) by the staff of Collier Podiatry P.A. I authorize release of information necessary to process any claim to my insurance company. I also agree that any balance not covered by my insurance company will be paid for by myself. I agree to notify this office of any changes of my insurance status and/or changes in coverage immediately. I agree that photocopies of this form will be as valid as the original.

– – – – – – – – – – – – – – – –**ASSIGNMENT OF BENEFITS**– – – – – – – – – – – – – –

I hereby assign all medical and/or surgical benefits to which I am entitled to due under my insurance policy for the amount to satisfy the fees for services rendered by Collier Podiatry P.A. I understand I am financially responsible for all charges whether or not paid by my insurance company. I also agree that any payments made to me by my insurance company for services rendered by Collier Podiatry P.A. will immediately be forwarded to this office.

______________________________________ ____________________

Signature of Patient or Legal Guardian Date

● Should your account be turned over to collections, a $35.00 fee will be applied. ●

COLLIER PODIATRY, P.A.

OFFICE FINANCIAL POLICY

● We are dedicated to providing the best possible care and service to you, while maintaining our patient's privacy and confidentiality. This requires your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff. We will assist you in obtaining all of the benefits for which you are eligible for and entitled to.

● We are Medicare participating providers. We will bill Medicare for you. You will be responsible for your annual deductible, co-payment and charges for non-covered services. You will be asked to sign an Advanced Beneficiary Notice form for services ***we know*** are not covered by Medicare. Medicare does cover surgery, X-rays and other treatments. Medicare ***does not cover*** routine foot care such as trimming of corns or cutting of toenails. ***You will need to pay*** for these services at the time they are provided.

● You must inform the office of all insurance changes and authorizations and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

● Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.

● Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period (60 days), ***you are responsible for payment***. Please assist us in settling your claim by periodically calling your insurance carrier and requesting they pay us in a timely manner.

● We have made prior arrangements with some insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. We will do our best to inform you of whether we accept or participate with your insurance company. This list changes frequently, so please check your benefits with your insurance company. We handle these claims in accordance with our agreement, if one exists. We will file your insurance as a courtesy. In the event we are not aware of a charge or service that is not covered by your plan, you will be billed after we receive a denial from your insurance company.

● Past due accounts are subject to collection proceedings, including the filing of a Medical Lien. All fees, including but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

● If you have insurance coverage with a plan in which we do not participate, we will submit the claim for you on an unassigned basis ***as a courtesy***. This means your insurer will send the payment directly to you. Therefore, ***all charges*** for your care and treatment ***are due at the time of service***. If the charges exceed $1000.00, you will be asked to pay 50% of the entire bill with the remaining balance due in 45 days. This gives you time to follow-up with your insurance company. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges to your plan's benefit schedule.

● We will not become involved in a dispute between you and your company regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity. We will supply factual information as necessary.

● There is a service fee of 25.00 for all returned checks. Your insurance company does not cover this fee.

● Your signature below signifies that you understand and agree to our financial policy and acknowledge your responsibility regarding charges incurred in this office.

______________________________	______________________________
Signature of Patient/Responsible Party	**Signature of Witness**
______________________________	______________________________
Printed Name of Above	**Printed Name of Above**
____________________	____________________
Date	**Date**

______________ **Patient initials to indicate copy received**.