FINESSE FOOTCARE

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

HEIGHT :_____

WEIGHT :_____

PRIMARY LANGUAGE: _____

RACE:_____ ETHNICITY:_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

LAST DATE SEEN BY PRIMARY CARE PHYSICIAN:_____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

HOW DID YOU HEAR ABOUT US?_____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization	Date	Reason For Hospitalization	Date

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ___ packs/day for ___ years

Use of Recreational Drugs: ☐ Never ☐ Quit How long ago? _____ Type _____
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease
☐ Rheumatoid Arthritis ☐ Other _____

Employer: _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

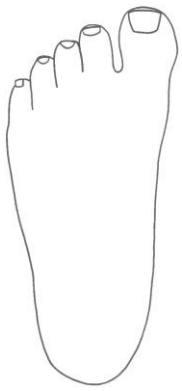
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

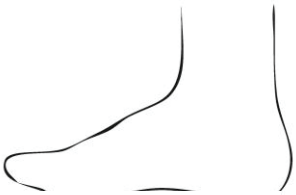
LEFT FOOT



TOP OF FOOT

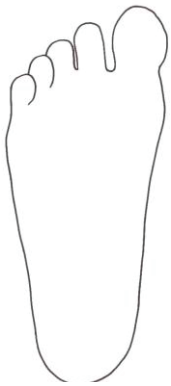
BOTTOM OF FOOT

INSIDE OF FOOT



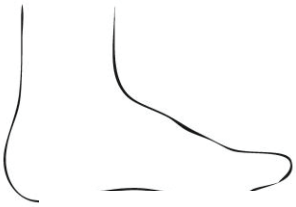
OUTSIDE OF FOOT

RIGHT FOOT

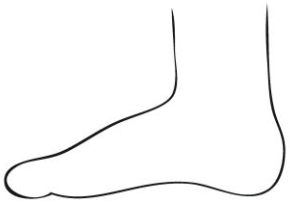


BOTTOM OF FOOT

TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____
Print name of patient, parent or guardian Signature of doctor

_____ _____
If other than patient, relationship to patient Date

_____
Signature

_____
Date

HIPAA Information and Patient Privacy Consent

Patient's Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- All other disclosures by the practice will require specific authorization by you unless required by law.
- The Practice has a Notice of Privacy Practices and that the patient can review this Notice and receive a copy. The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the web site.
- The patient has the right to restrict the uses of their information used for treatment, payment or operations, but the Practice does not have to agree to those restrictions.

_____ _____

Patient / Guardian Signature **Date**

_____ _____

Practice Staff Member Signature **Date**

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

As our patient, you are responsible for all authorizations needed to seek treatment in this office.

- 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 All Major Credit Cards, 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, we will have to look to you for payment.

- We have made prior arrangements with certain 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.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We will submit all claims to your insurance. In the event your insurance is not in Network, you will be responsible for any charges for the services provided to you.

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

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Revised November 2023