

# PATIENT INFORMATION FOR FAMILY FOOT CARE LLC

Patient Name: \_\_\_\_\_ Patient Sex: Male \_\_ Female \_\_

Patient SSN: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Patients Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Patients Employer: \_\_\_\_\_

**Please Circle:** Divorced Partner Married Separated Single Widowed

Spouses Name: \_\_\_\_\_ Spouses Date of Birth: \_\_\_\_\_

Spouses SSN: \_\_\_\_\_ Spouses Work or Cell Number: \_\_\_\_\_

Spouses Employer: \_\_\_\_\_

## **If patient is a child:**

Mothers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mothers SSN: \_\_\_\_\_ Mothers Work or Cell Number: \_\_\_\_\_

Mothers Employer: \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Fathers SSN: \_\_\_\_\_ Fathers Work or Cell Number: \_\_\_\_\_

Fathers Employer: \_\_\_\_\_

**Primary Insurance Company Name:** \_\_\_\_\_

Policyholders Name: \_\_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_

Policyholders Name: \_\_\_\_\_

**Third Insurance Company Name:** \_\_\_\_\_

Policyholders Name: \_\_\_\_\_

**\*\*\*Patients Primary Care Doctor/Pediatrician:** \_\_\_\_\_

Referred to our office by: \_\_\_\_\_

**Patients Pharmacy:** \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

## PATIENT MEDICAL INFORMATION

Patient Name: \_\_\_\_\_

Please list the reason(s) for seeing the doctor today: \_\_\_\_\_

\_\_\_\_\_

How long have you had the current problem you are being seen for today? \_\_\_\_\_

Is your visit related to an injury or accident? Yes or No

**If YES please provide work comp information before being seen or we will NOT bill today or any future visit(s) to the work comp company unless you provide proper information today. We also cannot go back and refile past visits to work comp.**

Please list all current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies: Please circle Yes (Y) or No (N).**

Penicillin: Y N Sulfa: Y N Codeine: Y N Aspirin: Y N

Adhesive Tape: Y N Latex: Y N Local Anesthesia: Y N

Other: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Shoe Size:** \_\_\_\_\_ **Width:** \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much and how often? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much and how often? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ (We ask this of our female patients as there is often a need for X-rays to be taken.)

**Medical Status: Please circle Yes (Y) or No (N).**

Diabetic: Y N Arthritis: Y N Rheumatoid Arthritis: Y N

High Blood Pressure: Y N Hepatitis: Y N If yes which one \_\_\_\_\_

HIV/Aids: Y N Kidney Problems: Y N Heart Problems: Y N

Cancer: Y N Bleeding Disorders: Y N Liver Problems: Y N

Gout: Y N

Please list any previous surgeries: \_\_\_\_\_

\_\_\_\_\_

# FAMILY FOOT CARES' FINANCIAL INFORMATION

**Please read and initial each statement below. If you have any questions, please ask.**

I, \_\_\_\_\_, authorize Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank to release information regarding my medical history and treatments to my insurance company in order for them to be paid. \_\_\_\_\_

I authorize payments for services to be paid directly to Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank from my insurance company. \_\_\_\_\_

I will ensure that Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank has my current insurance information and any referral I may need. \_\_\_\_\_

\*If I do not provide current insurance information or a current referral, I understand that I will be responsible for that day and any days charges forward until I provide current information, within a timely manner, so that my claim(s) can be processed by my insurance company. Failure to supply information will lead to my or my legal guardians full responsibility. \_\_\_\_\_

I understand there will be finance charges, late charges and a 25% attorney fee on any unpaid account. \_\_\_\_\_

I understand that any copays or self pay amounts are due at the time of service. \_\_\_\_\_

I understand that the staff and or Dr's of Family Foot Care are not aware of my personal insurance companies deductibles, coinsurance and or copays for my plan. It is my responsibility to find out that information. \_\_\_\_\_

I understand that at any time during or before my treatment I can ask and will receive an answer on the cost(s) of any treatment that is being performed or going to be performed on me. \_\_\_\_\_

I understand that if I am a Medicare patient and I am eligible for Diabetic shoes and inserts that they are **not** "free". Medicare will pay 80% of the allowed amount and then my secondary will pay the remaining 20%-IF i have the benefit. I understand there is a possibility that I may owe the 20% if my secondary does not cover it. \_\_\_\_\_

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, nite splint, ankle brace or powersteps, that they are **non-refundable and non-returnable.** \_\_\_\_\_

I understand that there is a fee for copies of medical records and X-rays. I also acknowledge that there are fees associated with any forms filled out by our office for my absence from work. \_\_\_\_\_

**I acknowledge by signing my name below as the patient or guardian of the patient that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.**

**Patient or Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office of Dr. Sophie Liu and Dr. Steven Frank  
Family Foot Care**

**Authorization of Medical Information**

Please read the following questions carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time. Please refer to our **HIPAA** notice located in our reception area and/or on our web page at [www.Familyfootcaremo.com](http://www.Familyfootcaremo.com).

\_\_\_\_ I have read and understand the HIPAA notice.

\_\_\_\_ I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CIRCLE** where we may leave a message if necessary:

**HOME      ANSWERING MACHINE      WORK      CELL PHONE**

May we discuss the patients medical condition with members of your family or friends?

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

If **YES**, please list below the name of that person and their relationship to the patient.

| <b>NAME</b> | <b>RELATIONSHIP TO PATIENT</b> |
|-------------|--------------------------------|
| _____       | _____                          |
| _____       | _____                          |
| _____       | _____                          |
| _____       | _____                          |

**EMPLOYER** **Employers Name**\_\_\_\_\_

**SHORT TERM DISABILITY** **FMLA**\_\_\_\_\_

Please list **ANY** information from your medical record at Family Foot Care that you would **NOT** wish to have disclosed:

\_\_\_\_\_  
\_\_\_\_\_

I give permission to Family Foot Care to release information, either verbal or written regarding my medical condition only, for the purpose of medical management.

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Signature of Patient/Legal Guardian)

\_\_\_\_\_  
(Date)

This release may be rescinded at any time in writing from the patient/legal guardian.