Superior Podiatry- New Patient form- Please Print

admin@superiorpodiatry.com

Full name_____

DOB:_____/_____/_____ Sex: M F Race_____

Address_____ City_____ State_____ Zip_____

Best Contact Number_____ Email_____

Marital status: (circle one) Single Married Widowed Partnered Divorced

Emergency Name _____ Phone_____ Relation_____

Primary Care Physician:_____ **Phone** _____

Pharmacy:_____ **Phone** _____

How Did you hear about our practice?

Internet/Google Friend/family Insurance Other Doctor Referral

Referred by: _____ **Other:**_____

Assignment Of Benefits & Authorization To Release of Information

If I am entitled to beneifits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan, (covering me or anyone legally responsible for me), in consideration for services provided to me by Superior Podiatry. I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered by to me. I authroize payment of benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hearby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, durable medical equipment and any charges for services deemed to be; not covered, not precertified, or not preauthorized by my insurance plan.**

_____(initial) I give my consent for examination and treatment by Superior Podiatry.

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

*Responsible party signature:(insured)*_____ *Date:*_____

*Responsible party signature:(self pay)*_____ *Date:*_____

If not signed by patient please indicate relationship to the patient

Relationship:_____ _____ Date:_____

Reason for Today's Visit

What is the reason for your visit today? _____

How long has this bothered you?_____

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

_____

Medical History

Have you had any past problems with your feet or ankles? __Yes __No

If yes, please describe: _____

Are you allergic to:
__Penicillin __Sulfa __Latex __Betadine(iodine) __Aspirin __Tylenol __Ibuprofen __Vicodin __Codeine
Other (specify)_____ __None of the above

Please indicate if you have a problem with the following:
__Alcoholism __Blood Disorders __Gout __Liver disease __Sleep Apnea __Seasonal Allergies __Cancer
__Deep Vein Thrombosis __Diabetes __Dialysis __Dyslipidemia __Fibromyalgia __Headaches __Aids/Hiv
__Hepatitis __Edema __Kidney Disease __Vascular disease __High Blood Pressure __Coronary Artery Disease
__Leg or Foot Ulcers __Organ Transplant __Osteoporosis __Pacemaker __Peripheral Vascular Disease __Polio
__Epilepsy/Seizures __Stroke __Rheumatoid Arthritis __Substance Abuse __Thyroid Problems __Varicose Veins

Do you have artificial joints? __Yes __No
If yes where?_____

Have you ever had any surgical procedures on your foot/ankle or anywhere else on your body?
__Yes __No If yes please describe?_____ **Date:**_____

Are you pregnant? __Yes __No **Are you nursing? __Yes __No**

Are you disabled? __Yes __No **Do you have an artificial heart valve? __Yes __No**

Current Medications:

_____

Family History

Mother: __Arthritis __Cancer __Diabetes __Heart Disease __Osteoporosis

Father: __Arthritis __Cancer __Diabetes __Heart Disease __Osteoporosis

Social History

Do you smoke? __Yes __No **Did you smoke in the past? __Yes __No** **If yes, how long**_____

Do You Have:

__Tired or achy legs __Heel pain __Calluses on your feet/toes __Pain at the ball of foot
__Uneven Footwear __Flat Feet __High Arch __Toe pain/numbness __Knee Pain __Hip Pain
__Lower back pain

If you answered YES to one or more of the above questions, you may be a candidate for orthopedic footwear.

1690 US 1 Hwy S, Suite C
St. Augustine, Fl 32084

Superior Podiatry
Foot & Ankle Specialists

9 Pine Cone Drive #101
Palm Coast, FL 32137

Phone: 904-436-8001 • **Fax:** 904-376-7761

Appointment Cancellation Policy

Dear Patient, Parent or Guardian of: **Date:_____**

Superior Podiatry has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

We are committed to the highest quality of care for all of our patients; therefore, we schedule all appointments in advance and make every attempt to confirm them.

1. Please provide our office a **24-hour notice** in the event that you need to cancel or reschedule.
2. **A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be assessed a $50 fee.**
3. The fee is not billable to your insurance.
4. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancelation policy remains in effect.
5. The 3rd missed appointment in a calendar year may result in the dismissal from the practice.

To ensure we do the best job possible keeping you informed about your appointments in a timely manner, we request that you frequently check your contact information we have in our files. Our staff is dedicated personally and professionally, to give you the concern, respect and care that makes our office a comfortable place to visit. We ask that you please call if you can not keep your scheduled appointment time.

By signing below, you have read, and understand this agreement.

Patient Name:_____ DOB:_____

Signature:_____ Relationship:_____