Kevin J. Powers, DPM & David R. Northcutt, DPM

The information on these forms is necessary for our office to obtain prior to your initial appointment. If the forms are not competed in its entirety, you will be delayed in seeing the doctor until the forms are complete. Thank you for your cooperation.

PATIENT INFORMATION

TODAY'S DATE: _____

First Name: _____ **MI:** _____ **Last:** _____

Date of Birth: _____ **Age:** _____ **Sex:** M or F **SSN:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **May we leave a message?** Y or N

Email Address: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Primary Language:** _____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐Other: _____

Marital Status: (mark one) ☐Single ☐Married ☐Divorced ☐Widowed

Employer/School: _____

Primary Physician: _____ **Date last seen:** _____

Preferred Pharmacy: _____ **Location:** _____

BILLING INFORMATION

Person Responsible for Payment: ☐ Self/Patient OR ☐ Other: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

EMERGENCY CONTACT

Name: _____ **Phone Number:** _____

Relationship to patient: _____ ☐ Authorized to access medical information (mark if yes)

☐ **Power of Attorney or** ☐ **Guardian:** _____ **Relationship:** _____

WHOM MAY WE THANK FOR REFERRING YOU?

☐ Doctor: _____ ☐ Internet ☐ Phonebook ☐ Insurance Company

☐ Friend/Family: _____ ☐ Other: _____

Appointments are confirmed by text or email (mark your preference): ☐Text ☐ Email

Phone messages may be left with (mark all that apply): ☐ Home Phone ☐ Cell Phone

☐Patient only ☐ Spouse/Child ☐ Parent/Guardian ☐ Anyone answering phone

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FINANCIAL AND PRIVACY POLICY CONSENT FORM

The following individuals are involved in my medical care/medical information and can be discussed or given to the following people: (If a friend/relative is not listed, information may not be released to them)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please initial by each section:

_____* **CANCELLATION AND NO-SHOW POLICY**

We require a 24-hour notice if you are not able to keep your appointment with our office. If notification is not given, you will be charged a no-show fee of $50.00 per missed visit. Please help us serve you better by keeping scheduled appointments.

_____* **PAYMENT AND CHARGES**

Payment is due at time of service. You will be responsible for paying any co-payments, coinsurance, deductibles, non-covered services, or supplies at the time of service. We accept Cash, Check, Debit/Credit card, and Care Credit. There will be a $25.00 charge for any returned checks. Services will be filed to your insurance. You understand that you are liable for any services denied by your insurance carrier. If payment is not made after reasonable notice of any balance due on your account, you will be responsible for any interest charges that can be added at the current legal rate and all collection effort fees, including attorney and court costs. *There will be a $45.00 charge for forms you request to be completed for FMLA, Disability, or various needs

_____* **INSURANCE BENEFITS**

As our patient, you are responsible for all authorizations and/or referrals needed to seek treatment in this office and must inform the office of all insurance changes and requirements. In the event the office is not informed, you will be responsible for any charges that are denied. I accept financial responsibility for payment of all deductible, co-insurance, and any other balances not paid by my insurance company. I authorize any holder of medical information about me to released to my insurance company and its agents any information needed to determine benefits payable to related services. I understand that my information, under certain circumstances may be released for one of the following reasons: 1) other healthcare professionals in order to coordinate my care, 2) insurance adjuster, if my claim is a work or motor vehicle injury 3) employer, if my claim is related to a work injury 4) attorney, if my claim is in a litigation process, 5) health insurance carrier for chart audit reason and for claim payment.

CONSENT

I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I understand my insurance policy is a contract between my insurance company and me. I hereby give permission to Dr. Powers Foot and Ankle, to administer treatment and to perform operative procedures as may be deemed necessary in the diagnosis, and/or treatment of my foot condition. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. I have read the above information and agree to the policies and procedures of Dr. Kevin Powers and Dr. David Northcutt.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

Witness (Office Staff): _____ **Date:** _____

Kevin J. Powers, DPM & David R. Northcutt, DPM

MEDICAL HISTORY

Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Allergies - please list all allergies OR ☐ NKA: _____

_____

_____

Medication List – please list ALL medications & dosages **OR** ☐ I have no medications

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Medical History – please mark any current or prior conditions

☐ Diabetes Type: ____ Most recent HgA1C result: _____ Date of last result: _____

☐ Acid Reflux
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis (☐ Osteo /☐ Rheum)
☐ Asthma
☐ Back Problems / Sciatica
☐ Blood Clot/ DVT
☐ Cancer: _____
☐ Cellulitis/Skin Infection (☐ MRSA)
☐ Circulation Problem
☐ Dementia/ Alzheimer's
☐ Depression/Anxiety
☐ Excessive/Easy Bleeding
☐ Fibromyalgia
☐ Foot/ Leg Ulcer
☐ Gout
☐ Heart Disease/Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Immune Disorder /HIV
☐ Kidney Disease (☐ Dialysis)
☐ Leg Cramps/Pain at Rest
☐ Liver Disease (☐ Hepatitis)
☐ Lung Condition: _____
☐ Mitral Valve Prolapse/Murmur
☐ Neuropathy
☐ Osteomyelitis/Bone Infection
☐ Parkinson's Disease
☐Pregnant or ☐Breastfeeding
☐ Rashes/Skin Condition
☐ Raynaud's Disease
☐ Seizure Disorder/Epilepsy
☐ Stroke (year_____)
☐ Stomach Ulcers
☐ Thyroid Condition
☐ Varicose Veins
☐ OTHER:_____
_____
_____
_____

Name: _____ **DOB:** _____

Surgical History

☐ Foot/Ankle Surgery: _____ ☐ Appendectomy ☐ Gallbladder

☐ Joint Replacement: _____ ☐ Tonsils/Adenoids ☐ Hernia Repair

☐ Stent Placement ☐ Thyroid ☐ Tubal Ligation ☐ Cesarean ☐ Hysterectomy

☐ Open Heart/Bypass Surgery ☐ Spinal Surgery ☐ Other: _____

_____

_____

Social History

Tobacco Use (mark one): ☐Current ☐Former ☐Never Packs/day: _____

Illicit Drug Use (current or past): _____

Alcohol Consumption: Yes or No Number of Drinks: _____ Per: Day / Week / Month / Socially

History of Present Illness

Please list the foot/ankle problem(s) you are experiencing: ☐ Right ☐ Left or ☐ Both

_____

_____

Date symptoms began: _____ **How was the problem onset?** ☐Sudden or ☐Gradual

The problem is: ☐ Worsening ☐ Improving ☐ Unchanged

Is it painful? _____ If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐Sharp ☐Dull ☐Aching ☐Throbbing ☐Cramping

☐Itching ☐Popping ☐Burning ☐Tingling ☐Clicking ☐Shooting

☐Stabbing ☐Other: _____

Describe previous treatment: _____

Have you seen a podiatrist before? ☐ Yes or ☐ No If so, who? _____

Is the problem from an injury? ☐ Yes or ☐ No If so, is it work related? ☐ Yes or ☐ No

I stand _____ % of my day.

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

Signature: _____ Date: _____