Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

Spouse/Partner Name: _____ **E-mail:** _____

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

Home #: _____ **Cell #:** _____ **Work #:** _____

Pharmacy: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Policy ID: _____

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Address: _____

Group ID: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Phone #: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Policy ID: _____

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Address: _____

Group ID: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Phone #: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

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

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above._____ _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Diabetes (type 1, type 2)
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Skin disorders *(specify)* _____
☐ Arthritis *(specify)* _____ ☐ Other (*specify)* _____
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History ☐ None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass Surgery ☐Cataract Surgery ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long? _____
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____
☐ No, I do not exercise regularly

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*
☐ Arthritis ☐ Cancer ☐ High Blood Pressure ☐ Bleeding disorders ☐ Circulation problems ☐ Strokes
☐ Hammer toes ☐ Blood clot ☐ Diabetes ☐ Heart disease ☐ Neurological
☐ Other (specify):_____

Current Medications ☐None ☐ I take the following Prescription or over the counter medications:
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Use the back of this form if more room is needed

Allergy ☐ No Known Allergies **Reaction**
☐ Penicillin _____
☐ Shellfish _____
☐ Sulfa _____
☐ Tape _____
☐ Latex _____
☐ Betadine *(iodine)* _____
☐ Aspirin _____
☐ Tylenol™ _____
☐ Ibuprofen _____
☐ Codeine _____
☐ Other *(specify)*_____ _____

Review of Systems *(Please check the box if you currently have any of these symptoms)*

Cardiovascular	☐leg pain when walking ☐fainting	☐fever ☐ palpitations	☐ chest pain/pressure ☐vascular disease	☐leg swelling ☐Valve Problems	☐cold hands/feet
Genitourinary	☐blood in urine ☐decreased frequency	☐hesitancy ☐excessive urination	☐incontinence ☐kidney disease	☐increased urgency ☐kidney stones	
Gastrointestinal	☐abdominal pain ☐diarrhea	☐heartburn ☐trouble swallowing	☐blood in stool ☐constipation	☐vomiting ☐increase appetite	☐ulcers ☐decrease appetite
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders
Neurological	☐tingling ☐tremors	☐weakness ☐paralysis	☐seizures	☐numbness	☐headaches
Musculoskeletal	☐back pain ☐sciatica	☐joint swelling ☐joint stiffness	☐muscle weakness ☐joint pain	☐muscle pain ☐joint instability	☐neck pain ☐arthritis
Respiratory	☐chest pain ☐shortness of breath	☐wheezing ☐emphysema	☐COPD	☐coughing	☐snoring

Practice Name: **Chart Number:**

Name: _____ **Date of birth:** _____

Race: _____ ☐I prefer not to answer ☐I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐I prefer not to answer ☐I do not know

Preferred Language: _____ ☐I prefer not to answer

Privacy Information Preferences

Did you receive a copy of the HIPAA Privacy Practice Notice: ☐Yes ☐ No

Do you want to be exempt from public reporting? ☐Yes ☐No
May we send mail to the address on file? ☐Yes ☐No
May we call the phone number on file? ☐Yes ☐No
May we leave voicemail on answering machine? ☐Yes ☐No
Will you allow internet based delivery reminders like email? ☐Yes ☐No
Who may we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son
☐ Other: _____

Smoking Status

☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ I decline to answer
☐ Smoker, Current status unknown
☐ Unknown if ever smoked

Vital Signs

Blood Pressure: _____ / _____

Height: _____

Weight: _____

☐I prefer not to answer ☐I do not know

Current Medications

_____
_____
_____
_____

☐ I am not taking medication ☐ I prefer not to answer

Allergies

_____
_____
_____
_____

☐ I do not have allergies ☐ I prefer not to answer

FINANCIAL POLICY

PAYMENT FOR SERVICES IS REQUIRED AT THE TIME SERVICES ARE RENDERED. We accept payment in form of cash, check and credit cards. Returned checks will be charged a $25 fee in addition to collection fees. Balances older than 90 days will be forwarded to a collection agency. We make every effort to remind patients of their appointments as a courtesy, but you are ultimately responsible for remembering to keep your appointment. You will be charged a $25 noshow fee for any appointment missed, non-cancelled or not rescheduled with at least 24 hours notice. A $10 fee will be assessed for completion of any personal forms (disability, etc). No original medical records or x-rays will be released. A $10 charge will assessed for duplicating your medical records and $5 fee will be assessed for duplicating x-rays (per film). All accounts must be current (have a $0.00 balance) before any medical records will be released.

POLICY ON PARTICIPATING INSURANCES

Please realize that **your insurance is a contract between YOU and your INSURANCE COMPANY** and you are ultimately responsible for payment. Furthermore, you are fully responsible for any co-payments/co-insurance and insurance deductibles at the time of visit. If your insurance coverage is not in effect at the time of service, you are fully responsible for payment at the time services are rendered. Further, you will be responsible for any medical services deemed "non-covered", "coverage terminated", "pre-existing" or denied by your insurance. Please note that we have no control over payers that do not cover certain services in some contracts**. IT IS YOUR RESPONSIBILITY to understand your insurance policy and services that are covered and/or not covered under your insurance policy**. Also some insurance companies require patients to obtain a referral prior to the visit. It is your responsibility to obtain a referral in order to avoid a charge for the visit. If your insurance company requires you to obtain a referral and you do not present it at the time of visit, we reserve the right to reschedule your appointment or collect the full price of the visit up front.

POLICY ON MEDICARE (FOR MEDICARE PATIENTS ONLY)

Please note that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% co-insurance of what Medicare allows. You are also responsible for services that Medicare does not cover. We may ask you to sign a Medicare Advanced Beneficiary Form (ABN), which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for payment at the time of visit. The filing of secondary insurance claims is a **courtesy** that we extend to our patients. We will make every effort to help you in the filing of your claims; however, all charges are ultimately **YOUR responsibility** after the initial filing with your insurance company.

POLICY ON NON-PARTICIPATING INSURANCES AND SELF-PAY

We are not participating with every insurance company available. If you are not sure if we are participating, we encourage you to call your insurance company to verify our participation. **Ultimately, it is your responsibility to know your policy.** For insurance companies that list us as non-participating or non-preferred providers and for our self-pay patients, **our office policy is to collect the full price of the visit up front.** We will extend the courtesy of filing with your insurance on your behalf after payment of all services rendered. Any questions about pricing should be addressed *prior* to treatments being rendered.

POLICY ON MEDICAID (FOR MEDICAID PATIENTS ONLY)

All Medicaid patients will be treated as self-pay patients except when Medicaid is a secondary payer to Medicare.

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby give permission to Dr. Lam, and/or his associates of Lam Family Foot Care, PLLC to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical and surgical care**.** I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such. I authorize payment of medical benefits be made on my behalf to Dr. Lam and/or his associates of Lam Family Foot Care, PLLC for any services furnished to me. I authorize the release of any medical information by Dr. Lam and/or his associates of Lam Family Foot Care, PLLC to my insurance carrier in order to process my claims.

In addition, the following individual(s) with whom my protected health information may be shared:

Name(s)_____Relationship(s)_____

I understand that the authorized individual(s) must present proper identification and this authorization will expire only upon receiving written notification from me. I understand that the practice reserves the right to deny access for any reason. Furthermore, I read and understood Lam Family Foot Care financial policy described above and agree to comply with all terms and conditions.

SIGNATURE : _____**Date** _____**/**_____**/**_____