



Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Patient Registration

Date: _____

Name: _____	How did you hear about us? _____
Address: _____	_____
City: _____	Marital Status: _____
State: _____ Zipcode: _____	Gender: M F
Date of Birth: _____	Employer Name: _____
SSN: _____	Work Phone: _____
Home Phone: _____	Family Physician: _____
Cell Phone: _____	Phone: _____
E-Mail: (Very important to us) _____	Emergency Contact: _____
_____	Phone: _____

Use this section if insurance is in patient's name.

Primary Insurance: _____
Insurance Numbers: _____
Secondary Insurance: _____
Insurance Numbers: _____

Use this section if insurance is in someone else's name.

Primary Insurance: _____
Insurance Numbers: _____
Secondary Insurance: _____
Insurance Numbers: _____
Insured relationship to patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent Other: _____

Insurance Verification:	Office Use: Do not fill out
Is insurance active? Y N	Co-pay: _____ Encounter Fee: _____ Deductible: _____
Is referral needed? Y N	Do we have one? Y N Orthotics covered? Y N
Any restrictions to foot care? _____	
Verified by: TM CM Other: _____	Date: _____



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Office Policy

Patients are expected to pay for their office visit at the time of service, unless we have verified that your health insurance covers office visits and will reimburse us directly. All copayments must be made at the time of service.

It is your responsibility to understand your insurance coverage. There are numerous types of insurance coverages available. If you are enrolled in a health maintenance organization (HMO) or some other type of managed care plan, you are required to have a written referral for each and every visit. We will not see you without your referral unless you are willing to pay for the visit. It is your responsibility to know your unique insurance requirements and arrange for your authorizations or referrals when necessary. Since we are not party to your agreement with your insurance carrier, it is not our policy to establish why they have not paid, or why they paid less than anticipated. You will need to contact your carrier directly for any questions regarding their reimbursement policies. You are personally responsible for any unpaid balances.

Many insurance policies require that you meet a specific annual deductible. In recent years deductibles can exceed \$10,000. Payment of your deductible is your responsibility. We do not absorb your deductible. We expect payment or payment arrangements immediately upon notification.

Unpaid balances are due upon receipt of your statement, unless payment arrangements have been made. If a balance is past due and you wish to be seen in our office we reserve the right to not treat you unless payment is made or at least partial payment is made and a payment plan is established.

If you have been involved in a car accident or work related incident, it is your responsibility to notify this office and provide authorization and bill information from your auto or worker's compensation carrier. We must have this information prior to your being seen.

Termination of care will result if your account becomes three months delinquent. We will bill your insurance company for most services; however, you are directly responsible for your account should your insurance company fail to pay us. Accounts not receiving any payments for over 6 months are subject to be sent to collection or settled in small claims court.

We reserve the right to settle any disputes with our office both financial and medical with binding arbitration.

We only send out three (3) statements and then turn the account over to **Associates Financial Solutions** for collection

We now use text messaging, e-mail and phone calls to notify you of your appointments, any current specials and account balances. E-mail is our preferred method. We never share or sell any e-mails in our system.

STARTING JULY 2017 THERE WILL BE A \$35.00 FEE CHARGED TO YOUR ACCOUNT IF YOU MISS AN APPOINTMENT.

Cell Phone: _____

Home Phone: _____

E-mail: _____

I have read the above office policy and agree to their terms.

Patient Signature: _____ Date: _____



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Patient History

Name: _____ Date of Birth: _____ Age: _____

Vitals: Last Blood Pressure _____ Last Blood Sugar _____ Height _____ Weight _____

Race: Asian American Indian Black(African American) Hispanic White

Other: _____

Drinking Status: None Social Moderate Heavy Former Drinker

Smoking Status: Never Smoked Smoke 1-5 times/day Smoke > 5/day ? PPD _____

Former Smoker- How many years ago? _____ How many packs/day? _____

Current Vaccinations: (Circle) Influenza - Pneumonia - Hepatitis A - Hepatitis B - Shingles - Tetanus

Other: _____

Current Medications: I currently do not take any medications.

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

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Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

If you take more than 11 medications please list on a separate sheet.

Allergies: No known Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

If you have more than 9 allergies please list them on a separate sheet.

Medical History: Alcoholism Blood Disorders Circulation problems Muscle pain
 Breathing issues Liver Sleep apnea Gout Allergies Heart disease
 Asthma Heart Murmur Stomach/Bowel issues Depression Anxiety Disorders
 Mental Illness Kidney Issues Blood Clots High Cholesterol High Blood Pressure
 Cancer Hepatitis Neuropathy Thyroid Disease Diabetes Arthritis
 HIV Skin Disorders CVA Stroke

Please add description or any other medical condition not listed.

Surgical History: Appendectomy C-Section Angioplasty Bypass Cataracts
 Joint Replacement Vascular Surgery Other Surgery: _____

Foot or Ankle surgery: _____

Occupational history: Retired Unemployed presently I walk stand sit at work
 Job Description: _____
 Exercise Level: I never exercise I exercise 1-3 times per week 4-7 times per week
 Please describe your exercise routine. _____

Falling History: I have not fallen in the past 12 months. I have fallen on the past 12 months.
 I have had loss of balance where I stumbled or tripped. I am unstable walking.

Family History: Is there and blood relation that suffers from the list below.? Please tell us what relation.

Alzheimers _____ Arthritis _____ Blood Clots _____
 Bleeding Disorders _____ Cancer _____ Cataracts _____
 Circulation Problem _____ Depression _____ Diabetes _____
 Emphysema _____ Heart Disease _____ Hypertension _____
 Neurologic _____ Strokes _____

Any other medical conditions run in your family? _____

Review of Systems: Circle if you have any of these symptoms or circle "NONE"

Cardiovascular	leg pain when walking palpitations	fever vascular disease	chest pain/pressure valve problems	leg swelling	cold hands/feet	fainting NONE
Genitourinary	blood in urine excessive urination	hesitancy kidney disease	incontinence kidney stones	increased urgency	decreased frequency	NONE
Gastrointestinal	abdominal pain trouble swallowing	heartburn decreased appetite	blood in stool increased appetite	vomiting	ulcers constipation	diarrhea NONE
Integumentary	athletes foot	nail abnormalities	keloids	itchiness	dry, scaly skin	NONE
Hematological	lower leg ulcers	sickle cell disease	anemia	blood thinners	clotting disorders	NONE
Neurological	tingling	weakness	seizures	numbness	headaches	tremors paralysis NONE
Musculoskeletal	back pain joint stiffness	joint swelling joint pain	muscle weakness joint instability	muscle pain	neck pain	sciatica NONE
Respiratory	chest pain emphysema	wheezing	COPD	coughing	snoring	shortness of breath NONE

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 on this form.

Patient Signature: _____ Date: _____



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Chief Complaint

Reason for Today's Visit

Date: _____

Patient Name: _____

Problem: _____

Location: _____

When did it start? _____ Days Weeks Months Years Mode of onset? Acute Chronic

Timing of pain: Constant Morning Night As day goes on Activity related With walking

With running/exercise Gets better with activity Start up pain Other: _____

Is the problem: Getting better Worse Staying the same Scale: 1 2 3 4 5 6 7 8 9 10

Is there swelling? Yes No Keeps you up at night? Yes No

Is there stiffness? Yes No Any clicking, laxity, giving out Yes No

Pain quality: Sharp Aching Stabbing Throbbing Burning Tingling _____

What makes the pain better? _____

What makes the pain worse? _____

Previous Treatment

Have you had a similar condition in the past? Yes No _____

Have you seen another physician for this? Yes No Who?: _____

Did you go to the ER or an urgent care for this? Yes No _____

Have you had any testing for this? Yes No

X-ray MRI CT Bone Scan Nerve Conduction Other: _____

Have you had an injection for this? Yes No How many?: _____

Have you gone to physical therapy? Yes No Did it help? Yes No

Have you had to use a mobility aid for this? Yes No

Which ones? Wheel chair Cane Walker Crutches Scooter Other: _____

Have you been immobilized? Yes No

Cast / # weeks _____ Cam Boot / #weeks _____ Brace / # weeks _____ Night Splint / # weeks _____ Orthotics

Have you had surgery for this? Yes No Who, what and when? _____

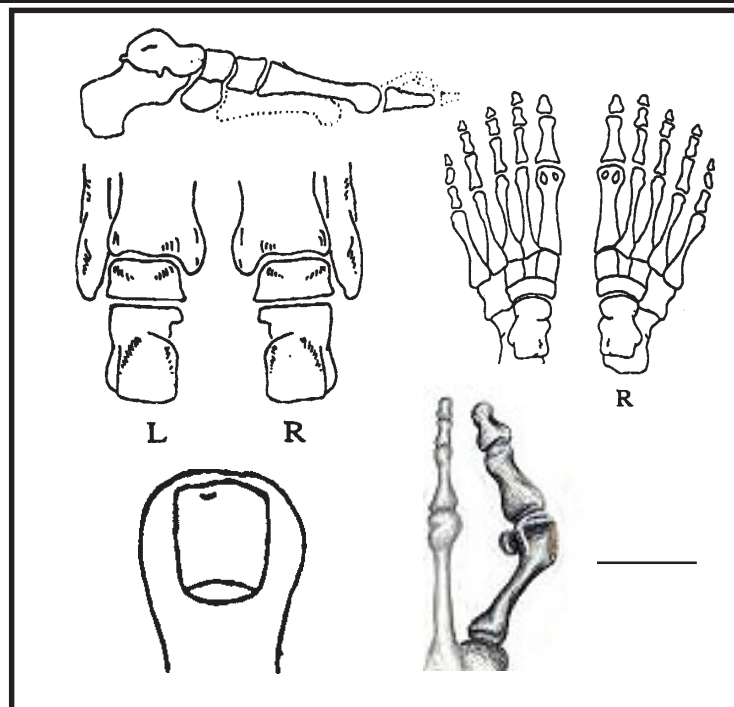
Anything else we need to know? _____

If you have more than 1 complaint ask for additional sheet.

Leave blank. We will fill in this page.

VASCULAR EXAM	Right	Left	NEUROLOGICAL	Right	Left
Pulses					
DP	NP 0 1 2 3 4	NP 0 1 2 3 4	Achilles Reflex	Abs Dec Hyp WNL	Abs Dec Hyp WNL
PT	NP 0 1 2 3 4	NP 0 1 2 3 4	Patellar	Abs Dec Hyp WNL	Abs Dec Hyp WNL
Cap Fill	Ins 1 2 3 4 >5	Ins 1 2 3 4 >5	Sharp/Dull	Abs Dec Hyp WNL	Abs Dec Hyp WNL
Temp Grad	W-W W-C C-C C-Cd	W-W W-C C-C C-Cd	Light Touch	Abs Dec Hyp WNL	Abs Dec Hyp WNL
Skin Texture	At Th Su Sh Dr WNL	At Th Su Sh Dr WNL	Hot/ Cold	Abs Dec Hyp WNL	Abs Dec Hyp WNL
Skin Color	Cy Bl Pa Ru WNL	Cy Bl Pa Ru WNL	Vibratory	Abs Dec Hyp WNL	Abs Dec Hyp WNL
Hair Growth	Inc Dec Abs WNL	Inc Dec Abs WNL	Monofilament	1 3 5 3mpj 5mpj WNL	1 3 5 3mpj 5mpj WNL
Skin Turgor	Inc Dec WNL	Inc Dec WNL	Clonus	Absent Present	Absent Present
Edema	Abs +1 +2 +3 +4	Abs +1 +2 +3 +4			

DERMATOLOGICAL	Right	Left
Blisters	_____	_____
Exfoliation	_____	_____
Fissures	_____	_____
Ingrown Nails	1 2 3 4 5	1 2 3 4 5
Mycotic Nails	1 2 3 4 5	1 2 3 4 5
Rashes	_____	_____
Ulcers	_____	_____
Varicose Veins	_____	_____
Verruca	_____	_____
Xerosis	1 2 3 4 5	1 2 3 4 5
Other:	1 2 3 4 5	1 2 3 4 5



ORTHOPEDIC	Right	Left
HAV	_____	_____
Tailors Bunion	_____	_____
Hammer Toes	1 2 3 4 5	1 2 3 4 5
HM	1 2 3 4 5	1 2 3 4 5
Contracted Toes	1 2 3 4 5	1 2 3 4 5
Depressed Mets	1 2 3 4 5	1 2 3 4 5
Foot Type	Planus Cavus WNL	Planus Cavus WNL
Other:	_____	_____
	_____	_____
	_____	_____
	_____	_____

QUALIFICATION FOR ROUTINE FOOT CARE

CLASS FINDINGS

Q7 - 1 class A Q8 - 2B Q9 - 1B 2C

Class A - nontraumatic amputation of foot or skeletal portion of

Class B - Absent PT or absent DP or advanced trophic changes (3 of the following) (hair growth absense, nail changes thickened, pigment changes/ discoloration, skin texture/thin or shiny, skin color/ rubor or redness)

Class C - Claudication, temp changes (hands vs ft), edema, paresthesia, burning

Diabetes mellitus -Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)-Buerger's disease (thromboangiitis obliterans)-Chronic thrombophlebitis-Peripheral neuropathies involving the feet

Other DX _____

Mycotic Nails L - 1 2 3 4 5 R - 1 2 3 4 5

Corns L - 1 2 3 4 5 R - 1 2 3 4 5

Callouses L - Heel 1 2 3 4 5 R - Heel 1 2 3 4 5