ADVANCED PODIATRY

Patient Appointment Policy

Patients are asked to arrive on time for their appointments. Patients are seen by Dr. Gagnon based on their appointment time, not by the time they arrive. If you arrive early, we will try to see you as soon as possible but patients that have appointments before you will be given priority. If you are unable to keep your appointment, please contact the office before 9:00 a.m. on the day of your appointment.

It will be at the discretion of Advanced Podiatry to charge a $50 fee for patients not showing up for appointments.

By signing this document I am confirming that I have read and understand the Patient Appointment Policy above.

_____ _____

Patient Signature **Date**

ADVANCED PODIATRY

WELCOME TO OUR OFFICE

Patient's Name: _____
First Name Middle Initial Last Name

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Preferred Contact: [ ] Home [ ] Cell**

May we text you appointment reminders? **[ ] Yes [ ] No**

Social Sec #: _____ **Date of Birth:** _____ **Email:** _____
Month / Day / Year

Sex: Male Female **Marital Status:** Married Never Married Widowed Divorced Other
(**If Married, Spouse's Name / Date of Birth**: _____/_____)

Preferred Language: English Spanish German Polish Other: _____

Race: Caucasian African-American Hispanic Other: _____ **Ethnicity - Hispanic?** [ ] Yes [ ] No

Employer: _____ **Phone:** _____ Full-Time Part-Time Retired Unemployed

Employer's Address: _____
Street City State Zip Code

Pharmacy Name & Location: _____

Primary Insurance: _____ **2ndary Insurance:** _____

Referred to us by: Friend: _____ Dr._____
Family Internet Saw Sign Yellow Pages Ins Bk/WebSite Orland Township MacNeal Other: _____

Subscriber (Write "Same" if policy is yours, or fill out if spouse/parent is policyholder)

Subscriber's Name: _____ **Relationship to Patient:** _____

Address (if different than above): _____
Street City / State / Zip

Date of Birth: _____ **Home Phone:** _____ **Cell Phone:** _____
Month / Day / Year

Employer: _____ **Work Phone:** _____

Emergency Contact & Person designated to receive your Protected Health Information

Name: _____ **Phone:** _____ **Relationship:** _____

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

Patient Signature: _____ **Date:** _____

Patient and/or Guardian Signatures

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understood the Notice.

Signature: _____ **Date:** _____

I hereby authorize payment for services rendered directly to *ADVANCED PODIATRY*. I agree that I am responsible for any portion not contractually covered by insurance as well as Service Fees ($10/month) on unpaid balances. If my account is turned over to Collection, I agree to pay an additional 25% over the unpaid balance including but not limited to filing fees, court costs, collection agency fees, and attorney fees. I certify that the information provided is true and correct and my insurance information is up to date.

Signature: _____ **Date:** _____

ADVANCED PODIATRY

Present Illness/Injury (Is today's visit the result of an accident/work injury? [ ] Yes [ ] No)

Foot/Ankle Problems you currently have or have had in the past:

Ankle Pain Athlete's Foot Bunions Corns/Calluses Cramps in Feet/Legs Flat Feet Heel Pain
Ingrown Nails Tired Feet Plantar Warts Numbness in feet, legs, toes Swelling in feet, legs, toes

Describe foot/ankle problem: _____

How long have you had this problem? _____ **Were you previously treated for this problem?** [ ] Yes [ ] No

Have you seen any other physician regarding your foot/ankle problem: [ ] Yes [ ] No

If yes, by whom and when: _____

Are you currently under a physician's care? [ ] Yes [ ] No **Reason?** _____

Primary Care Physician: _____ **City:** _____ **Phone:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____ Narrow Med Wide Extra-Wide

Smoking status? (Circle one) Never smoked Former smoker Current every day smoker Current some day smoker

Do you drink alcohol/beer? [ ] Yes [ ] No **If yes, how often:** 1-2/day 3+/day 1-2/wk 3+/week

At work, do you: Sit Stand Walk

Allergies (Prescription & Over-the-Counter Drugs)

Circle and/or list any allergies: No Known Allergies

Latex Penicillin Sulfa Codeine Iodine/Betadine Adhesive/Tape Vicodin Cortisone Aspirin/NSAIDS Local Anesthetics

Other: _____

Medications

Current prescription and over-the-counter drugs *including dosages*: None

Coumadin _____mg Warfarin _____mg Aspirin _____mg

Others (Please list below or provide a list we can copy)

_____ _____ _____

_____ _____ _____

Family History (Circle all that apply)

Patient has a family history (parents and brothers/sisters) of:

Anxiety/Depression	Emphysema	Liver Disease	Psoriasis/Skin Prob
Arthritis	Epilepsy	Neurologic Disorder	Respiratory Disease
Asthma	Gastrointestinal/Reflux/Ulcers	Neuropathy	Stroke
Cancer	Heart Disease	Osteoporosis	Varicose Veins
Cholesterol Problems	High Blood Pressure	Poor Circulation	
Diabetes	Kidney Disease/Dialysis	Prostate Problems	

ADVANCED PODIATRY

Medical History (Circle all that apply)

Do you have a pacemaker? [ ] Yes [ ] No **Any Implants?** [ ] Yes [ ] No **Any Artificial Joints?** [ ] Yes [ ] No

Describe: _____

Please *circle all* that apply to you in *each* category:

General: Weakness Fatigue Fever

Respiratory: Asthma Emphysema Shortness of Breath

Skin: Rashes Itchiness Lumps Dryness Color Changes Nail/Hair Changes

Cardiac: Heart Disease High Blood Pressure Murmur Rheumatic Fever

GI: Hepatitis Nausea/Vomiting Liver Problems Ulcers Cholesterol Problems

Urinary: Frequent Burning/Pain on Urination Kidney Problems

Circulatory: Leg/Foot Cramps Varicose Veins Blood Clots

M/S: Joint/Muscle Pains Stiffness Arthritis Gout

Neurologic: Weakness Numbness Tingling "Pins & Needles"

Endocrine: Diabetes Insulin Thyroid Excessive Thirst or Hunger

Surgery / Injury History

Any problems with anesthesia? [ ] Yes [ ] No **Describe:** _____

Surgeries/Injuries: _____

_____

_____

_____

_____

Treatment Consent / Assignment of Benefits

I hereby request and give permission for treatment of my foot/ankle condition(s) by Dr. Mark J. Gagnon, DPM (and whomever he may designate as his assistants) as he deems necessary. I understand that information relating to my medical condition may be released to my insurance company for claims purposes and I understand that this information may include my insurance identification number/social security number, as well as other personal information. I hold harmless Mark J. Gagnon, DPM, for any action taken by present or future insurers as a result of this information.

I understand the above and hereby state that the information I have provided is correct to the best of my knowledge.

_____/_____ _____/_____

Signature **Date** **Reviewed by** **Date**