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taubpodiatry.com

Welcome to Taub Podiatry

Thank your for choosing our office for your foot and ankle care. We strive to provide you with efficient and curteous attention at each of your visits. We respect your time and make every effort to see you at your appointed time. It is our hope that the following information will answer any questions that you may have about our office, if you have any questions, please feel free to ask.

Office Hours: Hours are by appointment. Appointments are available Monday through Thursday. Urgent appointments are available. We do not have an answering service. Voicemail is provided for your convenience; you may leave a message for a return call. If you have an after-hours emergency, please call 911 or go to the nearest emergency room.

Co-pays, Deductibles, and Billing: All co-pays and deductibles are due at the time of service. We also accept major credit cards.

Office Procedures: Our office utilizes government certified electronic medical record software. Most of our charting is done in the exam room. The appointment time you are given allows for 15 minutes of charting before you see the doctor.

Please limit your initial visit to one primary complaint to receive the most efficient and comprehensive care. We look forward to getting to know you and helping you improve and maintain your health

Please present your insurance card(s) to the front desk.

1. Demographic information

Patient Name: ____________

Sex: ○ M ○ F

D.O.B: ____________

Cell Phone: (write none if no cell phone) ____________

Home Phone: ____________

Primary Address ____________

City: ____________

State: ____________

Zip: ____________

Email address (none if no email) ____________

Marital Status:
○ Married ○ Single ○ Widowed ○ Divorced

Race:
○ White ○ Black ○ American Indian ○ Asian
○ Pacific Islander ○ Other

Ethnicity:
○ Hispanic ○ Non- Hispanic

How would you like to receive appointment reminders?
○ Phone Call ○ Text ○ Email

Primary Language ____________

All languages spoken ____________

How did you hear about us? ____________

Occupation ____________

Primary Insurance: (Self Insured: None) ____________

Policy ID #: ____________

Secondary Insurance: ____________

Policy ID #: ____________

Insured's name: ____________

Insured's Date of Birth ____________

Emergency Contact ____________

Emergency Contact's Phone number ____________

Emergency Contact Relationship
☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ POA
☐ Friend

Did your primary provider refer you to this office?
○ Yes ○ No

Primary Provider (none if no primary) ____________

Primary phone number (none if no primary) ____________

Pharmacy Name (local pharmacy) ____________

Pharmacy address ____________

I agree that all the medical and personal information provided is accurate to the best of my knowledge.

____________ Signature

____________ Date

2. Medical Questions

Height (feet/inches): ____________________ Weight (lbs): ____________________ Last Primary Visit: (none if no primary) ____________________

Are you a diabetic?
○ Yes ○ No

How long have you been a diabetic? ____________________

What type of diabetes do you have?
○ Type I ○ Type 2

Which treatment method is used?
○ Oral Medication ○ Insulin ○ Diet Control

Name of MD treating your Diabetes? ____________________

Most recent blood sugar: ____________________

Most recent A1C: ____________________

How often do you take your blood sugar? ____________________

3. Were you treated for any falls in the last year?

☐ Yes ____________ ☐ No ____________

Please describe your injury and treatment provided

____

4. Do you have a local Vascular Surgeon?

○ Yes ○ No

Vascular Surgeon's Name

____

5. Social History

Do you smoke? (cigarettes, vaping)
○ Yes ○ No

If Yes, how often?
○ Multiple a day
○ Once a day
○ Every other day
○ On occasion

How long have you been smoking?
○ less than 5 years
○ 5-10 years
○ 11-20 years
○ 20-40 years
○ 50 or greater years

Did you used to smoke?
○ Yes ○ No

Do you drink alcohol?
○ Yes ○ No

If Yes, Amount:
○ Daily ○ Weekly
○ Occasionally
○ Socially

6. What is your complaint?

____
____
____
____

7. Where is your pain/problem located specifically?

	Ankle	Heel	Arch	Top of Foot	Bottom of Foot	Ball of Foot	Between Toes	Toenails
Right Foot								
Left Foot								

8. How long have you had this complaint/condition?

____

9. Did the problem result from a specific injury?

○ No ○ Yes

If yes, please describe

____

10. Please rate your pain on a scale of 1-10 (with 10 being the most painful)

	Your pain from 1 to 10
At rest	
At its worst	

11. What kind of pain is it?

	Constant	Occasional	Sharp	Dull	Aching	Stabbing	Throbbing	Radiating/Traveling
The pain is...								

Other

____

12. What symptoms are you experiencing?

	Locking	Numbness	Giving Away	Popping	Tingling	Burning	Grinding	Swelling	Bruising
I have...									

Other

____

13. Does anything make your symptoms feel better or worse?

____

____

____

____

14. Have you seen another physician for this problem?

- ○ No
- ○ Yes

Physician's name

____

15. What treatments have you tried?

	Nothing	Physical Therapy	Injections	Bracing	Icing	Compression	Medications	Shoe Change	Arch Support	Massage
Have Tried										

Other

____

16. Have you had any of the following test/studies for this condition/complaint?

	X-Rays	Blood Test	MRI	CT Scan
Tests				

If so, where were the test preformed?

____

17. Please list all current medications or provide a medication list.

18. Please list allergies including medication, tape, and latex allergies.

	Allergies
1	
2	
3	
4	
5	

19. Please choose all of your current and past medical history.

- ☐ I DO NOT HAVE ANY MEDICAL PROBLEMS ______________
- ☐ ANEMIA ______________
- ☐ ANXIETY ______________
- ☐ ARTIFICAL CARDIAC VALVES ______________
- ☐ ASTHMA / BRONCHITIS ______________
- ☐ BLEEDING DISORDER ______________
- ☐ BLOOD CLOTS ______________
- ☐ BPH (ENLARGED PROSTATE) ______________
- ☐ CANCER ______________
- ☐ CARDIAC VALVE DISEASE ______________
- ☐ CONGESTIVE HEART FAILURE ______________
- ☐ DEMENTIA ______________
- ☐ DEPRESSION ______________
- ☐ DIABETES TYPE 1 ______________
- ☐ DIABETES TYPE 2 ______________
- ☐ EMPHYSEMA ______________
- ☐ ENDOMETRIOSIS ______________
- ☐ EPILEPSY ______________
- ☐ GASTROINTESTINAL ISSUES ______________
- ☐ GERD (REFLUX) ______________
- ☐ GOUT / ELEVATED URIC ACID ______________
- ☐ HEPATITIS A ______________
- ☐ HEPATITIS B / C ______________
- ☐ HERNIATED DISC ______________
- ☐ HIGH BLOOD PRESSURE ______________
- ☐ HIGH CHOLESTEROL ______________
- ☐ HIP REPLACEMENT ______________
- ☐ HIV/ AIDS ______________
- ☐ HYPOTHYROIDISM ______________
- ☐ IRREGULAR HEART BEAT ______________
- ☐ KNEE REPLACEMENT ______________
- ☐ LIVER DISEASE ______________
- ☐ LUPUS ______________
- ☐ LYMPHEDEMA ______________
- ☐ KIDNEY DISEASE ______________
- ☐ MIGRAINES ______________
- ☐ NEUROPATHY ______________
- ☐ NEUROMUSLCAR DISEASE ______________
- ☐ OSTEOPENIA/OSTEPOROSIS ______________
- ☐ OSTEOARTHRITIS ______________
- ☐ OVERACTIVE BLADDER ______________
- ☐ OXYGEN DEPENDENT ______________
- ☐ PACEMAKER ______________
- ☐ PARKINSON'S DISEASE ______________
- ☐ PCOS (POLYCYSTIC OVARIES) ______________
- ☐ PERIPHERAL ARTERIAL DISEASE ______________
- ☐ POOR CIRCULATION ______________
- ☐ PTSD ______________
- ☐ RHEUMATOID ARTHRITIS ______________
- ☐ STROKE ______________
- ☐ SWELLING IN LEGS ______________
- ☐ ULCERS / WOUNDS ______________
- ☐ OTHER ______________
- ☐ OTHER ______________

Taub Podiatry Financial Policy

Patient's Name: ______________________ DOB: __________

Printed Name of Person Signing Form: ______________________ Relationship to Patient: ______________________

Patients, or Legal Guardians of patients under the age of eighteen, must sign and date below before medical care can be rendered.

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/coinsurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

By signing I agree that I have read, understood and agree with Taub Podiatry's Financial Policy.

______________________ Client Signature

__________ Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, CONSENT TO PHOTOGRAPH, VIDEO AND/OR OBTAIN DIGITAL IMAGES, And CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to read the Notice of Privacy Practices, which is kept in the patient lobby and contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Taub Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the policy of Dr. Taub. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to Taub Podiatry to contact me by phone and it is ok to leave detailed message related to my medical condition.

I authorize Taub Podiatry to discuss my medical history with the following people:

Name: ______________________ Relationship: ______________ Phone Number: ______________

Name: ______________________ Relationship: ______________ Phone Number: ______________

I agree that Taub Podiatry may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes and consent to the use of electronic prescribing as federally mandated.

______________________ ______________

Client Signature Date