

PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthday _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Spouse's/Parent's Name _____

Birthday _____ SS# _____

Occupation _____

Spouse's/Parent's Employer _____

Email Address: _____

3 PHONE NUMBERS

Home _____ Work _____ Ext _____

Cell _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?
(Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a podiatrist before? Yes No
Is there any personal or family history of diabetes? Yes No

Name _____ Yes No

Last Visit _____

Your Occupation _____

Cigarette/Tobacco Use Yes No

Years Smoked _____

Athletic activities in which you participate _____
(please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain Yes No Heel Pain Yes No

Athlete's Foot Yes No Ingrown Toenails Yes No

Bunions Yes No Plantar Warts Yes No

Corns/Calluses Yes No Swelling in Ankles Yes No

Cramps/Numbness Yes No or Feet Yes No

in Feet or Legs Tired Feet Yes No

Foot or Leg Cramps Yes No

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. **Elizabeth Kroboth, D.P.M.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, including Medicare and Medical.

Responsible Party Signature

Relationship

Date

5 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins

Pharmacy Names(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

6 ALLERGIES

Adhesive/Tape

Local Anesthetics

Aspirin

Penicillin

Codeine

Sulfa

Iodine/Betadine

Anti-inflammatories

Other _____

7

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves		Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B, C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

Surgeries you have had

Hospitalization other than for the surgeries listed

Are you on any blood thinners? Coumadin Warfarin Plavix Other

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

Welcome and thank you for choosing this office for your Podiatric/foot care need. In our continuing effort to provide personalized patient care in most efficient and economical manner possible, we ask that you take a few moments to read our financial policy and fill out our medical history forms. Your clear understanding of our financial policy and fill out our medical history forms. Your clear understanding of our financial policy is important to our professional relationships. If you have any questions about our fees, or your financial responsibilities for services rendered, please don't hesitate to ask us. We are a Medical provider and are also members of various PPO insurance plans. It is **your** responsibility to make sure we are on **your insurance plan**. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that this is in place prior to your appointment, we will be glad to help if we can.

Please remember that the agreement you have with your insurance company does not affect your responsibility for payment and all fees are ultimately due from you. Most health insurance plans will leave you with a co-payment, deductible, or sometimes a balance for non-covered services. Please be prepared to pay your portion at the time of service.

We will be happy to bill your insurance company as a courtesy to you. If you have a secondary insurance company we will also bill them. If balances due are not paid within 30 days of receipt of your statement, an additional rebilling fee \$12.00 will be added to your account to cover the cost of rebilling. **Please do not set up your own repayment plans.** Payment plans must be authorized by **Dr. Kroboth**. Please note any and all courtesy discounts given to you initially will not take effect, in the event you fail to make timely payments.

Complete payment for all podiatric soft goods, orthotics, supplies and medications are due on the date these supplies are issued and these products are **non refundable**.

If any reason you need to cancel your appointment, please give us a 24-hour notice.
Thank you.

CONSENT

I certify that the above information is true and correct to the best of my knowledge and agree with the Financial Policy. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's/Parents' Signature _____ Date _____

SOUTH SHORE PODIATRY ASSOCIATES

ELIZABETH A. KROBOTH, D.P.M., P.A.

Diplomate, American Board of Podiatric Surgery

Fellow, American College of Foot and Ankle Surgeons

350 TEXAS AVENUE, SUITE B

WEBSTER, TX 77598

TELEPHONE: (281) 535-3800

FAX: (281) 535-3805

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due, in full, at time of service, unless you have made other financial arrangements, in advance, with our business office. If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract. However, we require that **ALL CO-PAYS OR DEDUCTIBLES** be paid at the time of service. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company. We accept Cash, Check, MasterCard, Visa, Discover or American Express. Returned checks will be subject to an additional \$25 service fee.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered. **The patient is responsible for filing claims with secondary insurance companies.**

We do participate with Medicare and Medicaid and are preferred providers for the following plans:

Aetna (all plans)	Beechstreet	Blue Cross/Blue Shield (all plans)
Cigna (PPO, Open Access Plus)	HealthSmart	PHCS
United Health Care	Unicare	Great West
First Health	Integrated Health Plan	

You will be required to show a copy of your insurance card and driver's license at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.

Our time, as is yours, is very valuable and if for some reason you cannot make your scheduled appointment, please be kind and call us at least 24 hours in advance. If you fail to show for your appointment, your account will be assessed \$25.

If you have questions regarding this information, please do not hesitate to ask us. We are here to help you.

I hereby understand the financial policy set forth by South Shore Podiatry Associates. I guarantee payment of all charges incurred for the account of the patient below. I further agree to pay any attorney's fee, court costs and related collection fees incurred.

Print Name _____
Date

Responsible Party Signature _____

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HIPAA Compliance Privacy Notice

By signing below, I acknowledge I have read and accept the policies set forth in the "Notice of Privacy Practices" provided to me by South Shore Podiatry Associates.

Print Name

Signature

Date

(If you would like a copy of the "Notice of Privacy Practices" please inform anyone at the Front Desk and we will be happy to accommodate you.)

* * * * *

To obtain more information regarding your privacy rights or if you have questions you want answered about your privacy rights, you may contact the practices HIPAA Compliance Officer:

Dr. Elizabeth A. Kroboth

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PATIENT ACKNOWLEDGMENT STATEMENT

WAIVER FORM

I understand certain procedures, services or supplies are not a covered benefit or deemed “not medically necessary” by my Insurance Company. I also understand that my insurance plan or its health insurance agent determines the benefit coverage of these services. If I choose to have these procedures, services or receive supplies not payable by my Insurance Company, I understand I am responsible to pay these charges in full.

Services include, but are not limited to: trimming of toenails, corns and calluses.

Specialized items include, but are not limited to: Ace bandages, PPT/Plastizote innersoles, Coban, Elastoplast, custom orthotics, post-operative shoes, Orthotech walkers, aircasts and other footcare products.

Print Name

Patient Signature

Parental Signature (if patient is a minor)

Date

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Name: _____

Date: _____

Medical History (Review of Systems)

Please indicate if you have, or have ever had, any of the following :

Constitutional

<input type="checkbox"/> Fever	<input type="checkbox"/> Recent Weight Loss >10 lbs
<input type="checkbox"/> Other	<input type="checkbox"/> Recent Weight Gain >10 lbs
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chronic Fatigue

Integumentary (skin)

<input type="checkbox"/> Skin rash	<input type="checkbox"/> Moles	<input type="checkbox"/> Ulcerations
<input type="checkbox"/> Hives	<input type="checkbox"/> Deformed Nails	<input type="checkbox"/> Bruises
<input type="checkbox"/> Alopecia	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Itching	<input type="checkbox"/> Abrasions	<input type="checkbox"/> Eczema
<input type="checkbox"/> Infection	<input type="checkbox"/> Discolorations	<input type="checkbox"/> Other

Eyes

<input type="checkbox"/> Wear Glasses/Contacts	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Other
<input type="checkbox"/> Vision loss	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blurring of vision

Ears/Nose/Throat

<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Other
<input type="checkbox"/> Nose Pain	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Ear Noises
<input type="checkbox"/> Nose Bleeding	<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Nose Discharge		

Gastrointestinal

<input type="checkbox"/> Nausea	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Ulcer/Gastritis	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Difficulty Chewing/Swallowing
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Constipation
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Bloody or Black Stool
<input type="checkbox"/> Gas	<input type="checkbox"/> Other
<input type="checkbox"/> Liver Trouble	

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Name: _____

Date: _____

Review of Systems (Continued)**Cardiology**

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Pulse
<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Defibulator / Pacemaker
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Swelling in Leg /Ankle / Foot
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Leg Pain / Cramps at Night
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Leg pain when walking
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Weakness / Tiredness
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Other

Musculoskeletal

<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Sprains	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Hip pain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Back pain
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Fractures	<input type="checkbox"/> Club Feet	
<input type="checkbox"/> Partial/Complete Amputation		

Neurology

<input type="checkbox"/> Headache	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Weakness
<input type="checkbox"/> Stroke	<input type="checkbox"/> Confusion	<input type="checkbox"/> Gait Difficulties
<input type="checkbox"/> Parkinson	<input type="checkbox"/> Muscle Jerking	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Balance Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Tremor
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Tingling/Numbness	<input type="checkbox"/> Restless Leg Symptoms
		<input type="checkbox"/> Seizures

Respiratory

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Asthma
<input type="checkbox"/> Coughing Phlem	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Other

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Name: _____

Date: _____

Review of Systems (Continued)**Endocrinology**

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Heat/Cold Intolerance
<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hormonal Problems
<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Other

Hematology/Lymph

<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Take Aspirin
<input type="checkbox"/> Anemia	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Other
<input type="checkbox"/> Take Coumadin	<input type="checkbox"/>

Genitourinary

<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Pain / Burning with Urination	<input type="checkbox"/> Kidney Transplant
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> On Dialysis
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Kidney Infection	

Allergy

<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other drugs
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Any foods
<input type="checkbox"/> Iodine	<input type="checkbox"/> Any Chemicals
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Adhesive tape
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other

Psychology

<input type="checkbox"/> Depression	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Post Partum Depression
<input type="checkbox"/> Suicidal Ideations	<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Anxiety