POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

PATIENT INFORMATION

Date:_____

Name:_____

Address:_____

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

Home Phone:_____

Cell Phone:_____

Work Phone:_____ext._____

Email address:_____

Best way to contact me by phone: Home / Work / Cell

Date of Birth:_____

Social Security No:_____

Primary Care Physician:_____

Phone#:_____**Fax#:**_____

Date Last Seen: _____

Gender: □Female □Male

Marital Status: □Minor □Single □Married □Divorced □Separated □Widowed □Engaged

Primary Language: □English □Spanish □Arabic □Chinese □French □Italian □Japanese □Portuguese □Russian □Other

Race: □Asian □White □Black or African American □American Indian or Alaskan Native □Native Hawaiian or Pacific Islander □Other

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Emergency Contact:_____

Relationship to Patient:_____

Home Phone:_____

Work Phone:_____

PATIENTS UNDER 18

Relationship to Patient: Self / Spouse / Parent / Other

Accompanying Adult Name:_____

INSURANCE INFORMATION

Primary Insurance Company:_____

ID#:_____**Grp#:**_____

Name of Insured:_____

Date of Birth:_____

Relationship to Patient: Self / Spouse / Parent / Other

Gender: □Female □Male

Do you have additional insurance? □Yes □No

IF YES, PLEASE COMPLETE THE FOLLOWING:

Secondary Insurance Company:_____

ID#:_____**Grp#:**_____

Name of Insured:_____

Date of Birth:_____

Relationship to Patient: Self / Spouse / Parent / Other

Gender: □Female □Male

Name of Employer:_____

PHARMACY PREFERENCE

Primary Pharmacy:_____

Address:_____

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

Phone:_____

RESPONSIBLE PARTY

Relationship to Patient: Self / Spouse / Parent / Other

Name:_____

SSN#:_____ **Date of Birth:**_____

Gender: □Female □Male

Address:_____

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

Cell Phone:_____

Email address:_____

Employer:_____

Occupation:_____

Work Phone:_____

Who may we thank for referring you?

_____

Financial Policy for Potomac Podiatry Group

- *Payment in full is due at time of service unless prior arrangements have been made.*
- *Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a billing fee of $6.00 added for the administrative costs of billing.*
- *If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 45 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 45 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts in our office.*
- *HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.*
- *Please present your insurance card each time you visit if we participate with your plan to insure proper filing information to submit claims.*
  **Otherwise your visit may not be covered and you will be responsible for payment.*
- *There is a $35.00 charge for all returned checks.*
- *Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours' notice. If you miss a scheduled appointment without notifying our office a $50.00 charge will be added to your account.*
- *If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees and/or attorney fees by these services.*

ASSIGNMENT OF BENEFITS/PRIVACY POLICY

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Potomac Podiatry Group all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/ or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I authorize Potomac Podiatry Group to use the Health Information Exchange Network in order to provide more comprehensive medical treatment.

By my signature I acknowledge reviewing the financial and privacy policies and hereby agree to their terms.

*Printed Name:*_____

*Signature*_____ *Date:* _____

I acknowledge receiving Potomac Podiatry Group's Notice of Privacy Practices (posted in the office and on the website).

*Signature:*_____ *Date:*_____

I authorize the following individuals to receive information on my behalf. This includes medical information.

*Name & Relationship:*_____

*Name & Relationship:*_____

*Name & Relationship:*_____

REASON FOR VISIT

What is the chief complaint for which you came to be treated? _____

Have you ever been to a Podiatrist before? ☐Yes ☐No If yes, please explain:_____

Athletic activities in which you participate:_____

TOBACCO/SOCIAL HISTORY

Smoking Status: Are you a Tobacco User? ☐Yes ☐No
If yes, how many packs per day?____ How many years of smoking?____

☐Current Smoker, Everyday ☐Heavy Tobacco Smoker ☐Light Tobacco Smoker

☐Former Smoker ☐Never ☐Unknown, if ever smoked

Do you drink alcohol? ☐Yes ☐No Do you use drugs? ☐Yes ☐No Other Social History:_____

GENERAL MEDICAL HISTORY
Place a check mark next to any of the following that pertain to your medical history

- ☐ Alcoholism
- ☐ Allergies/Hay fever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Coronary Artery Disease
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Colitis
- ☐ Depression
- ☐ Other Medical History:_____
- ☐ Hospitalizations:_____
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Dialysis/Kidney Problems
- ☐ Fracture
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ TIA/Stroke
- ☐ Tuberculosis

SURGICAL HISTORY

- ☐ No prior surgical history
- ☐ Appendectomy
- ☐ Breast Lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Cone Biopsy
- ☐ D & C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Mastectomy (Left Right Bilateral)
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal Ligation

MEDICATIONS ***(include prescriptions, over-the-counter & vitamins)***

MEDICATION	DOSE	MEDICATION	DOSE

ALLERGIES

☐ No known allergy history	☐ Demerol	☐ Novocain
☐ Adhesive/Tape	☐ Iodine	☐ Penicillin
☐ Anti-coagulant	☐ Latex	☐ Seafood
☐ Aspirin	☐ Local Anesthetic	☐ Sulfa
☐ Codeine		
☐ Other_____		

FAMILY HISTORY

Mother Past Medical History _____

Father Past Medical History _____

Brother Past Medical History _____

Sister Past Medical History _____

Is there a Family History of any of these disorders?

☐ Allergies	☐ Arthritis (any)	☐ Cancer
☐ Diabetes	☐ Epilepsy	☐ Gout
☐ Heart Attack	☐ Hypertension	☐ Kidney Disease
☐ Mental Illness	☐ Migraines	☐ Spinal Disorder
☐ Tuberculosis	☐ Other _____	☐ Other _____

VITALS

Height:_____ **Weight:**_____ **A1C:** _____

ADDITIONAL CLINICAL NOTES: