

The Foot Doctors, P.C.  
929 E. Montclair, Suite 100  
Springfield, MO 65807  
417-883-1881  
Toll Free 1-800-366-8377

Welcome to The Foot Doctors, P.C.

We would like to take this opportunity to welcome you to our practice. At our office, our Doctors and staff will always put your comfort first. You'll discover our special type of care the moment you make your first contact with our office. Our staff will greet you warmly and do their best to make you feel at ease.

Your appointment is scheduled with Dr. \_\_\_\_\_

Your appointment date is \_\_\_\_\_

In order to prepare your initial records and prepare your new patient chart, it is essential that you complete your paperwork prior to your arrival. Please arrive by \_\_\_\_\_ with your completed paperwork.

If you cannot make this time, we will need to reschedule your visit. If you need to reschedule your appointment, please call our office at least 24 hours in advance. If you are 10 minutes or later for your appointment, it may be necessary to reschedule your appointment to a later date.

Enclosed you will find a map showing directions to our office and the paperwork we will need at the time of your visit. Please fill in the requested information and bring it with you along with a photo ID and any insurance cards you may have.

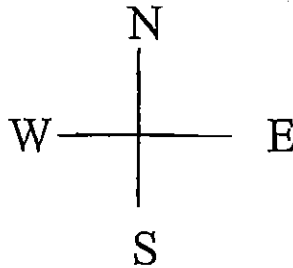
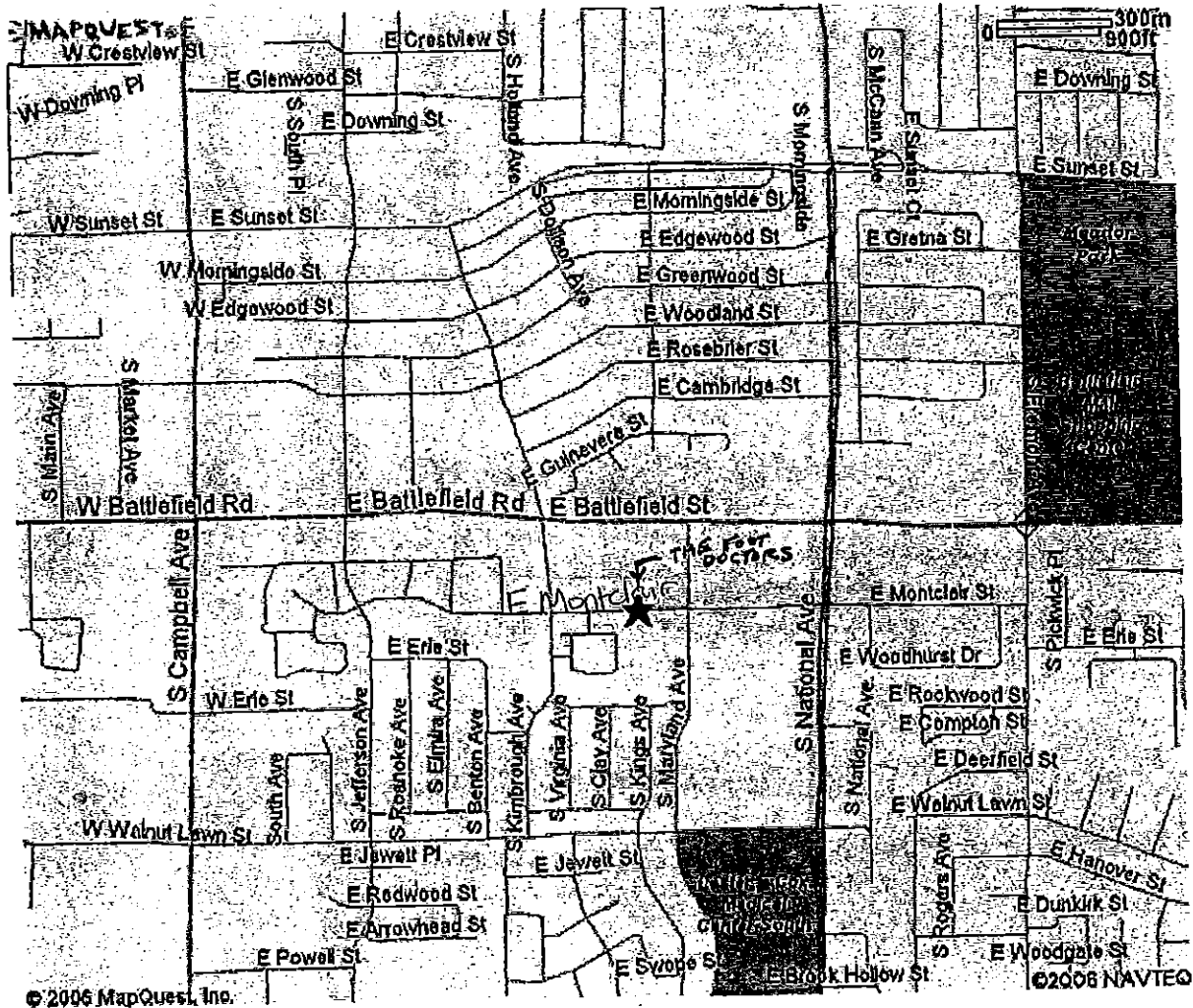
If you have any questions before your appointment, please call our office at the above number.

Thank you for choosing our clinic to service your foot care needs. We look forward to seeing you soon.

Sincerely,  
The Foot Doctors, P.C.  
Doctors and Staff

**\*\* PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY \*\***

THE FOOT DOCTORS, P.C.  
929 E. MONTCLAIR, STE. 100  
SPRINGFIELD, MO 65807  
1-800-FOOT-DRS  
(417) 883-1881



**THE FOOT DOCTORS, P.C**

WELCOME TO THE FOOT DOCTORS, P.C.

**PATIENT INFORMATION:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\*\*\*\*\*

Spouse's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone # \_\_\_\_\_

OR

Parent/Guardian \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

\*\*\*\*\*

Please advise us who referred you to our office. We would like to thank them.

Dr. \_\_\_\_\_ Family/Friend \_\_\_\_\_ Other \_\_\_\_\_

\*\*\*\*\*

**INSURANCE INFORMATION: PLEASE BRING INSURANCE CARD TO APPOINTMENT**

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address for Claims: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Group # \_\_\_\_\_

Record Release I give permission for The Foot Doctors, P.C. to release my records to my insurance company.

Referral Policy If my insurance company required me to have a referral to see a specialist, I must contact my primary care physician to

have the referral in your office by the date of my appointment and to maintain a current referral for all subsequent visits. It is my responsibility to obtain this referral for all subsequent visits. If an approved referral is not obtained, I will be responsible for my medical treatment charges if my insurance company does not pay.

Payment Policy The Foot Doctors, P.C. will file all insurances if the correct information is provided. PPO/HMO charges will be handled in accordance with the policies. Medicare is accepted by assignment. If you have not met your deductible for the year, you will be responsible for that amount. I hereby authorize payment directly to the physician if I allow The Foot Doctors, P.C. to file my insurance. I understand that if my account is turned over to a collection agency due to non payment, I will be responsible to pay the

cost of collections, court and legal fees in addition to the balance owed.

SIGNATURE (PATIENT/RESPONSIBLE PARTY) \_\_\_\_\_ DATE \_\_\_\_\_

## HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

REASON FOR CURRENT VISIT/BRIEF HISTORY \_\_\_\_\_ PHONE (    ) \_\_\_\_\_

**HISTORY OF PAST ILLNESS:** Have you had?

Measles .....	No	Yes	Stroke or Heart Attack .....	No	Yes
Mumps.....	No	Yes	Rheumatic Fever or Heart Disease.....	No	Yes
Chickenpox.....	No	Yes	Congenital Abnormalities or Birth Defects.....	No	Yes
Cancer.....	No	Yes	Tuberculosis.....	No	Yes

Have you ever been hospitalized or been under medical care over night?    No    Yes  
If yes, for what reason? \_\_\_\_\_

**Injuries:**

Have you had any broken bones, sprains, dislocations?    No    Yes    Describe

Family History	Health if Living	if deceased Age (at death) And Cause
_____	_____	_____
Father	_____	_____
Mother	_____	_____
Brother/	_____	_____
Sister	_____	_____
Son/	_____	_____
Daughter	_____	_____

<b>Has Any Blood Relative Had?</b>		
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Stroke	No	Yes
Convulsions, Paralysis	No	Yes
Cirrhosis Hepatitis	No	Yes
Thyroid Disease	No	Yes
Bleeding Tendency	No	Yes
Gout	No	Yes
Arthritis	No	Yes

**SOCIAL HISTORY:**

Single    Married    Separated    Divorced    Widowed  
 Are you living with your husband or wife?.....No    Yes  
 Do you live alone?.....No    Yes  
 Alcoholic beverages: Never    Rarely    Moderately    Daily \_\_\_\_\_  
 Tobacco: Cigarettes \_\_, Packs Per Day \_\_, Don't Smoke \_\_, Ever Smoked \_\_\_\_\_  
 Other Recreational Drugs \_\_\_\_\_  
 Are you exposed to fumes, dusts, or solvents? \_\_\_\_\_

**Head-Eyes-Ears-Nose-Throat**

Eye disease or injury.....	No	Yes
Do you wear glasses?.....	No	Yes
Double Vision.....	No	Yes
Headaches.....	No	Yes
Glaucoma.....	No	Yes
Itching eyes or nose.....	No	Yes
Sneezing or runny nose.....	No	Yes
Nosebleeds.....	No	Yes
Chronic sinus trouble.....	No	Yes
Ear Disease.....	No	Yes
Impaired hearing.....	No	Yes
Dizziness or transient episodes of unconsciousness.....	No	Yes

**SYSTEMIC REVIEW:** Do you have any of the following?

**General**

Last physical examination \_\_\_\_\_  
 Last tetanus shot \_\_\_\_\_  
 Changes in appetite (eat more/less).....No    Yes  
 Recent weight change.....No    Yes  
 Excessive thirst.....No    Yes  
 Have you been in good general health most of your life.....No    Yes

**Respiratory**

Long term or frequent cough.....	No	Yes
Long term sore throat.....	No	Yes
Asthma or wheezing.....	No	Yes
Difficulty breathing.....	No	Yes
Pneumonia.....	No	Yes

**Skin**

Skin diseases.....No    Yes  
 Jaundice.....No    Yes  
 Hives, eczema or rash.....No    Yes  
 Frequent infections or boils.....No    Yes  
 Abnormal pigmentation.....No    Yes

**Neck**

Stiffness.....	No	Yes
Enlarged glands.....	No	Yes

**SYSTEMIC REVIEW: Do you have any of the following?**

Cardiovascular

Chest pain or angina pectoris.....No Yes  
 Shortness of breath w/walking or lying down.....No Yes  
 Heart trouble or heart attacks.....No Yes  
 Swelling of hands, feet or ankles.....No Yes  
 Phlebitis or blood clots.....No Yes  
 Heart murmur.....No Yes  
 Blood pressure problems.....No Yes  
 Any pain in calves or buttocks on walking  
 that is relieved by rest.....No Yes

Gastrointestinal

Peptic ulcer (stomach or duodenal).....No Yes  
 Vomiting blood or food.....No Yes  
 Liver trouble.....No Yes  
 Hepatitis.....No Yes  
 Painful bowel movements.....No Yes  
 Bleeding with bowel movements.....No Yes  
 Recent change in bowel habits.....No Yes  
 Frequent diarrhea.....No Yes  
 Heartburn or indigestion.....No Yes

Genitourinary

Frequent urination.....No Yes  
 Night time urination.....No Yes  
 Burning or painful urination.....No Yes  
 Blood in urine.....No Yes  
 Kidney trouble.....No Yes  
 Kidney stones.....No Yes

Gynecological

Any reason to suspect you may be pregnant.....No Yes  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_

REACTIONS TO MEDICATIONS

Penicillin.....No Yes  
 Morphine, Codeine, or Demerol.....No Yes  
 Novocain or other anesthetics.....No Yes  
 Aspirin, Empirin, or other pain reliever.....No Yes  
 Sulfa drugs.....No Yes  
 Tetanus antitoxin or other serums.....No Yes  
 Adhesive tape.....No Yes  
 Iodine, IV dye, or merthiolate.....No Yes  
 Other.....No Yes

Name of Primary Care Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Referring Physician \_\_\_\_\_  
 Signature of Patient \_\_\_\_\_  
 Source of information if other than patient \_\_\_\_\_

Locomotor/Musculoskeletal

Varicose veins.....No Yes  
 Leg cramps with activity.....No Yes  
 Leg cramps in bed at night.....No Yes  
 Heel pain, arch pain with  
 prolonged activity.....No Yes  
 Burning feet.....No Yes  
 Ankle or knee pain w/activity.....No Yes  
 Shin splints.....No Yes  
 Joint pain or morning stiffness.....No Yes

Neuro-Psychiatric

Convulsions.....No Yes  
 Paralysis.....No Yes

Hematologic

Are you slow to heal after cuts.....No Yes  
 HIV.....No Yes  
 Anemia.....No Yes  
 Abnormal bruising or bleeding.....No Yes

Endocrine

Thyroid disease.....No Yes  
 Diabetes.....No Yes  
 Hormone therapy.....No Yes  
 Change in hair growth.....No Yes  
 Have you become more cold.....No Yes  
 Has your skin become more dry.....No Yes

Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Shoe Size \_\_\_\_\_

Describe Reaction

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**CONSENT FOR TREATMENT:** As a patient of The Foot Doctors, P.C., I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and/or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary. This would also include, but not limited to, the performance of services involving pathology and radiology.

**AUTHORIZATION FOR DISCLOSURE:** I give express permission to discuss with the individual(s) I have listed:

PLEASE CHECK THE APPROPRIATE LINE

Any aspect of my health care     Health information only     Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM:**

This Notice of Privacy Practices of The Foot Doctors, P.C. sets forth the ways in which my personal health information may be used or disclosed The Foot Doctors, P.C., and outlines my rights with respect to such information. I acknowledge that on \_\_\_\_\_ (date),

\_\_\_\_\_ I received a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

\_\_\_\_\_ I declined a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

\_\_\_\_\_ I was previously provided a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

Date \_\_\_\_\_  
Patient, parent if minor child, or guardian    Date  
(If patient unable to sign, representative's name)

\_\_\_\_\_  
Primary insured, if different from patient  
Secondary insured, if different from patient  
Guarantor, if different from patient

A copy of this authorization shall be as effective and valid as the original

The Foot Doctors, P.C.  
Springfield, Missouri

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of Information:** I authorize the disclosure of any or all of the information in my medical record to: (a) Any person, corporations, or agency responsible for all or part of The Foot Doctors services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to The Foot Doctors treatment or services; (b) This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers. (c) I further authorize The Foot Doctors, at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.
2. **Assignment of Benefits:** I assign to The Foot Doctors and/or the Independent Contract Groups named in the Notice of Privacy Practices, the benefits due me covering The Foot Doctors services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
3. **Medicare Patient:** I authorize The Foot Doctors to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.
4. **Financial Obligation for The Foot Doctors, any Physician Employee of The Foot Doctors, and the Independent Contract Groups named in the Notice of Privacy Practices:** I agree that I am financially responsible for payment of all amounts for services provided by The Foot Doctors and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between The Foot Doctors and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, copay, or coinsurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.
5. **Guarantor's Responsibility:** I have read and understand the financial obligations above and agree to the terms as stated.

\_\_\_\_\_  
Patient, Parent if minor child, or guardian  
(If patient is unable to sign, Representative name and relationship)

\_\_\_\_\_  
Date

A copy of this authorization shall be as effective and valid as the original



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### OUR FINANCIAL POLICY

We want to make the financial portion of your visit as simple as possible. To provide quality care, reduce your cost and eliminate misunderstandings we would like to advise you of our payment policy.

1. If you do not carry insurance, full payment is expected at the time of service.
2. If you have insurance, please consult your insurance benefits handbook or call your insurance carrier if you are not certain of your responsibility. Your copay is due at the time of your visit.
3. If you carry Medicare and a supplemental insurance, no payment is required if your deductible has been met. If you carry Medicare only, a payment of 20% will be expected once payment has been received from Medicare.
4. Please present all current insurance information at the time of your visit. **If a referral is required, it is the insured's responsibility to provide this before service is rendered.**
5. For your convenience, we gladly accept cash, check, MasterCard and Visa.

If you have any questions or concerns, please do not hesitate to contact us. WE WANT TO HELP YOU.

Thank you,

The Foot Doctors, P.C.  
Doctors and Staff