Pocono Foot & Ankle Consultants, P.C.
Nazareth Foot & Ankle Consultants
Easton Foot & Ankle Consultants

PODIATRIC MEDICINE, SURGERY AND WOUND CARE

Health Information Sheet

Name: _____ Date: _____
(First, Middle, Last)

Mailing Address: _____
Number Street City State Zip

Physical Address (if different):_____
Number Street City State Zip

Patient Home Phone #:_____ Cell #:_____

Employer: _____ Work #:_____

Email Address: _____

Date of Birth: _____ Sex: M F Age: _____

Social Security #:_____

Race/Ethnicity: _____ Language: _____

Height: _____ Weight: _____ Shoe Size: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widow

Do you use tobacco? Yes No

Do you consume alcohol? Yes No If yes, how often? _____

Have you had your Pneumonia Vaccine Yes No Date_____

Have you had your Covid-19 Vaccine Yes No Date _____

Primary Care Physician: _____ Date last seen: _____
(First and Last Name) (Mm/dd/year)

Endocrinologist: _____ Date last seen: _____
(First and Last Name) (Mm/dd/year)

Cardiologist: _____ Date last seen: _____
(First and Last Name) (Mm/dd/year)

Pharmacy (Name and Location):_____

What is the reason for your visit today? _____

_____

_____

Patient or Legal Guardian Signature: _____ **Date:** _____

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Patient Name: _____ **DOB:** _____

Do you have any allergies? Yes No List: _____

_____

Do you have or have YOU ever been treated for any of the following?

Alcoholism/Drug Rehab	Cancer	Hepatitis	Neuropathy
Anemia	Circulation Problems	High Cholesterol	Osteoporosis
Arthritis	Diabetes	HIV/AIDS	Psychiatric Disorder
Asthma	Epilepsy	Hypertension	Stomach Ulcer
Back Pain	Gout	Kidney Problems	Stroke
Blood Clot	Gerd	Liver Disease	Thyroid Disease
Bunion	Heart Attack	Lung Disease	Ulcer/Wound

Do you have any FAMILY HISTORY (mom, dad, aunt, uncle) of any of the following?

Arthritis	Diabetes	Hypertension
Bleeding Disorders	Foot Deformities	Osteoporosis
Cancer	Heart Disease	Stroke

Do you use any of the following assistive devices?

Walker	Cane	Crutches
Wheelchair	Braces	

Have you ever had foot surgery? Yes No List: _____

_____

_____

_____

Medical History/Surgeries? Yes No List: _____

_____

_____

_____

Medications currently taking: _____

_____

_____

_____

_____

Patient Initials _____

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Patient Name: _____ **DOB:** _____

PRIMARY Insurance Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Social Security#: _____

Relationship to Patient: _____

SECONDAY Insurance Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have/has insurance coverage and I assign directly to Pocono Foot & Ankle Consultants, P.C. 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits may be made to Pocono Foot & Ankle Consultants, P.C. for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____ _____
Responsible Party Relationship Date

OFFICE POLICIES

I acknowledge and understand that I am responsible for a **no-show fee of $25.00** if I do not show for a scheduled appointment and do not call the office prior. Also, a **late fee of $10.00** will be assessed if my co-payment is not paid at the time of service.

_____ _____ _____
Responsible Party Relationship Date

I acknowledge that I have the right to review Pocono Foot & Ankle Consultants, P.C. Notice of Privacy Practices. This notice describes how Pocono Foot & Ankle Consultants, P.C. may use and disclose my protected health information, certain restrictions, on the use and disclosure of my healthcare information as well as the rights I may have regarding my protected health information.

_____ _____ _____
Responsible Party Relationship Date

Patient Initials _____

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Patient Name: _____ **DOB:** _____

Medical Information Preferences

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

PLEASE INDICATE YOUR PREFERENCES

□ I give permission to **leave medical information** pertaining to me, my dependent or child, at the numbers listed below:

Method	Yes	No	Phone #
Home Phone			
Cell Phone			
Work Phone			
Email			

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

□ Do **not release medical information** to anyone other than myself.

□ I give **permission to release medical information** pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Phone #

Comments: _____

_____

_____

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Patient Initials_____