Todays Date: _____

Primary Physician Name & Phone Number: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male / Female

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

Address: _____

City: _____ State: _____ Zip: _____ Home Phone ( )_____

Email Address: _____ Cell Phone ( )_____

Marital Status: (circle one) Single Married Divorced Widowed Social Security #_____
(LAST FOUR DIGITS REQUIRED)

Emergency Contact Name: _____ **Phone Number:** _____

Relationship of Emergency Contact: _____

PRIMARY INSURANCE-SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: ( ) _____ Social Security # (**REQUIRED**): _____
Employer: _____ Work Phone: ( ) _____
Type of Insurance: _____ Policy #_____ Group # _____

SECONDARY INSURANCE- SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: ( ) _____ Social Security # (**REQUIRED**): _____
Employer: _____ Work Phone: ( ) _____
Type of Insurance: _____ Policy #_____ Group # _____

COMMERCIAL - MEDICARE - SELF PAY - MVA - PERSONAL INJURY - WORKMAN'S COMPENSATION

I request that payment of authorized benefits be made either to me or on my behalf to Foot & Ankle Specialists of Bucks County for any services furnished me by this office. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I hereby authorize my insurances to furnish to the above named office any information regarding my insurance claims under Title XVIII of the Social Security Act. I request that payment of Authorized Medigap benefits be made wither to me or on my behalf to the Foot & Ankle Specialists of Bucks County for any services furnished me by that physician/supplier. I authorized any holder of medical information about me to my Medigap Carrier any information needed to determine these benefits payable for related services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any services rendered by The Foot & Ankle Specialists of Bucks County. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original. I/We understand that I/We are responsible for reasonable attorney fees, court costs and cost of collections on any account that becomes delinquent by 45 days. **There is a $35.00 (thirty five dollars) charge cash or credit card (ONLY) payment <u>due immediately</u> on ALL returned checks.**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty five dollar ($35.00) for the first offense and then fifty dollar ($50.00) fee for any subsequent missed appointment. This fee will not be covered by your insurance company. A 25% finance charge will be added if and when the account is placed with a collection agency.**

X_____ **NAME OF INSURED:**_____
(signature) (please print name of insured)

Patient Name:_____ Date of Birth:_____

Today's Date: _____ Family Physician: _____

Height: _____ Weight: _____ (LBS.) Shoe Size: _____ Shoe Width:_____

Your local pharmacy information (Name & phone number): _____

Mail order pharmacy information (Name): _____

1. Please describe your current foot and/or ankle problem in detail: _____

_____

_____

2. How many days, weeks, months, or years have you had this problem (specific)_____

3. Have you been previously treated for this problem? If so, by whom and when? _____

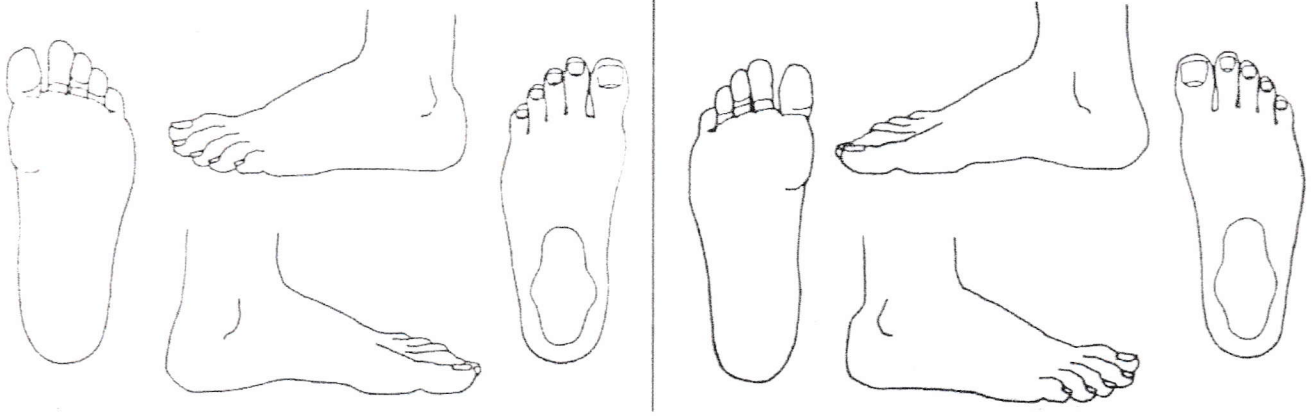
_____

4. Is this related to a Workman's Compensation, Personal Injury or Motor Vehicle Accident? YES NO

If so, please list: _____

Please Mark The Area Of Concern Below:

LEFT RIGHT



How were you referred to our practice? ☐ Insurance Directory ☐ Sign ☐ Patient / Friend

☐ Employee ☐ Doctor ☐ I was a previous patient ☐ Google/Internet

Whom may we thank?_____

Have you had previous treatment for other foot and ankle problems? If so, when, why and with whom?_____

_____

_____

_____

Do you smoke cigarettes? ☐ Non Smoker ☐ Former Smoker ☐ Light cigarette smoker (1-9 cigarettes per day)
☐ Moderate cigarette smoker (10-19 cigarettes per day) ☐ Heavy cigarette smoker (20-39 cigarettes per day)
☐ Very heavy cigarette smoker (40+ cigarettes a day) ☐ Cigar smoker ☐ Pipe smoker ☐ Chew tobacco

Do you consume alcohol? ☐ None ☐ Daily ☐ Weekly ☐ Socially ☐ Occasionally ☐ Past alcohol abuse

Medical History

Anemia	YES	NO	High Blood Pressure	YES	NO
Arthritis	YES	NO	HIV-AIDS	YES	NO
Asthma	YES	NO	Hyperthyroid	YES	NO
Back problems	YES	NO	Hypothyroid	YES	NO
Explain: _____			Kidney Problems	YES	NO
Bleeding problems	YES	NO	Liver Problems	YES	NO
Blood Clots (DVT)	YES	NO	Neuropathy	YES	NO
Blood Transfusion	YES	NO	Pacemaker	YES	NO
Cancer	YES	NO	Peripheral Artery Disease	YES	NO
Type/Year: _____			Phlebitis	YES	NO
Circulation problems	YES	NO	Psoriasis	YES	NO
Cholesterol	YES	NO	Pulmonary Embolism	YES	NO
COPD	YES	NO	Rheumatic Fever	YES	NO
Diabetes (Type _____)	YES	NO	Rheumatoid Arthritis	YES	NO
Drug Dependency	YES	NO	RSD/CRPS	YES	NO
Emphysema	YES	NO	Sciatica	YES	NO
Epilepsy	YES	NO	Sickle Cell Anemia	YES	NO
GERD	YES	NO	Sickle Cell Trait	YES	NO
GI Ulcers	YES	NO	Stroke	YES	NO
Gout	YES	NO	OTHER: _____		
Heart Murmur	YES	NO	_____		
Heart Trouble	YES	NO	_____		
Hepatitis (Type _____)	YES	NO			

Family History (Please circle YES or NO) ☐ **Unknown Family History/Adopted**

			List Family Member				List Family Member
Arthritis	YES	NO	_____	Diabetes	YES	NO	_____
Blood Clots (DVT)	YES	NO	_____	Heart Disease	YES	NO	_____
Cancer	YES	NO	_____	Other: _____			
Bad Circulation	YES	NO	_____	_____			

Consent for Treatment

I hereby give permission to Dr. Steven M. Remus / Dr. A. Paul Savelloni / Dr. Thomas B. Birdwell to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem(s).

X _____ _____

Signature Date

Relationship to Patient (if patient is a minor)_____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SURGICAL HISTORY (Please include entire surgical history including surgeries not on your foot and ankle).

☐ **No previous surgeries**

OPERATION	YEAR	REASON

MEDICATIONS (Please include any over the counter medications)

☐ **Not currently on any medication**

Medication Name	Milligram	How many times a day do you take this medication?	Why do you take this medication?

ALLERGIES ☐ **NO KNOWN DRUG ALLERGIES**

ALLERGIC TO	REACTION

FOOT & ANKLE SPECIALISTS
OF BUCKS COUNTY

Dr. Steven M. Remus, D.P.M., F.A.C.F.A.S.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons

Dr. A. Paul Savelloni, D.P.M., M.H.A., F.A.C.F.A.S.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons

Dr. Thomas B. Birdwell, D.P.M., A.A.C.F.A.S.
Associate, American College of Foot and Ankle Surgeons

3554 Hulmeville Road, Suite 104
Bensalem, PA 19020
(215) 245-1818
FAX: (215) 245-9129

360 N. Oxford Valley Road
Langhorne, PA 19047
(215) 946-3338
FAX: (215) 946-3338

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____

Release of information

☐ I authorize the release of my medical information including the diagnosis, records, examination and claims information. This information may be released to the following:

☐ Spouse _____ (Name)

☐ Children _____ (Name)

☐ Other _____ (Name and relationship)

☐ My information is not to be released to anyone.

****This release of my information will remain effective until termination in writing****

CONSENT FOR TEXT/VOICE MESSAGE AND EMAIL APPOINTMENT CONFIRMATIONS

Please mark below how you would like to receive your automated appointment reminders. I understand that by marking these options I consent to receiving automated reminders.

☐ Cell Phone Number: _____

☐ E-mail Address: _____

☐ I refuse to have automated appointment confirmations and by marking this option I understand that that I will receive no appointment reminder or confirmation.

Signature: _____ Date: _____/_____/_____

NOTICE OF PRIVACY PRACTICE

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION;

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care and/or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, a means of communication among the many Health Professionals who contribute to your care and as a legal document describing the care you received. It is also a means by which you or a third-party payer can verify that services billed were actually provided, a tool in educating health professionals, a source of data for medical research, a source of information for public health officials charged with improving the health of the nation, a source of data for facility planning and marketing, and a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your medical record and how your health information is used, helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosures to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that compiled It, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health records. If a copy is requested you will be responsible for a charge to duplicate these records. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations or revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we were unable to agree to a requested restriction and we will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in the office. We will not use or disclose your health information without your authorization, expect as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have question or concerns and would like additional information, you may contact the Office Manager, Rose DeGregorio at our normal business number 215-245-1818. If you believe your privacy rights have been violated, you can file a complaint with the office manager or with the medical assistants on the floor. There will be no retaliation for filing a complaint.

I hereby have read and understand the above information supplied to me.

X_____

SIGNATURE DATE