*Dr Scott Peters & Associates-Specialists of the Foot & Ankle*

**Patient Name**:_____ Date:_____

**How were referred to us?** Internet/Google [ ] Phonebook [ ] Insurance Company [ ]
Another Patient **[ ]** _____Primary Care Dr **[ ]**_____
Hillcrest Hospital [ ] Other [ ]_____

**Date of Birth:**_____ **Age:**_____ **SS #**_____- _____-_____
**Patient:** [ ] Male [ ] Female **Language:** [ ] English [ ] Other _____
**Race:** [ ] White [ ] Black/African/American [ ] Asian [ ] Other_____
**Ethnicity:** [ ] Non-Hispanic/Latino [ ] Hipsanic/Latino [ ] Patient declines

**Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Widowed **How long**?_____
**Children**: [ ] Yes [ ] No If yes, how many Boys _____ Girls _____
**Smoking**: Have you ever smoked? [ ] Yes [ ] No If yes, do you still smoke? [ ] Yes [ ] No
If you previously smoked and quit: Start date_____End date_____
**Height**_____ **Weight**_____ **Shoe Size**_____

**Patient Address:**_____
**City**_____**State**_____**Zip Code**_____
**Home Phone:**_____ **Cell Phone:**_____
**Email Address:**_____
**May we leave a message ?** [ ] Yes [ ] No

**Primary Care Physician**_____
**Physician Address**_____
**City**_____**State**_____**Zip Code**_____
**Physician Phone #**_____**Fax #**_____

**Employed: Yes [ ] No [ ]** **Retired: Yes [ ] No [ ]**
**Company Name:**_____**Occupation** _____
**Work Phone #**_____ **May we call you at work: Yes [ ] No [ ]**
**Student [ ] School Name**_____**Grade**_____

**In case of Emergency whom may we notify:**_____
**Phone #:**_____ _____**Relationship to Patient:**_____
**Responsible Party (if a minor)**_____**Relationship to Patient:**_____

**Pharmacy Name you Prefer**_____
**Pharmacy Location**_____**Phone:**_____

## INSURANCE INFORMATION

**Subscriber Name:**_____**Policy #**_____
**Insurance Co**_____**Subscriber DOB:**_____ **SS#**_____

## MEDICAL INFORMATION

**(Please CHECK all of the following that pertains to you and your parents + Year Diagnosed)**

| CONDITION | PATIENT | MOTHER | FATHER |
|---|---|---|---|
| Acid Reflux (GERD) | | | |
| Anxiety | | | |
| Arthritis | | | |
| Asthma | | | |
| Bronchitis | | | |
| Cancer: **(Specify Type)** | | | |
| Circulation Problems | | | |
| Depression | | | |
| Diabetes: **(Specify)** Type 1 [ ] or Type 2 [ ] Oral [ ] Insulin [ ] Both [ ] | | | |
| Emphysema | | | |
| Epilepsy/Seizures **(Specify)** | | | |
| Gall Stones | | | |
| Gout | | | |
| Heart Attack (Year) | | | |
| Heart Disease (Specify) | | | |
| Heart Murmur | | | |
| Herpes | | | |
| Hiatal Hernia | | | |
| High Blood Pressure | | | |
| High Cholestrol | | | |
| HIV+ AIDS | | | |
| Liver Disease (Specify Type) | | | |
| Lung Problems (Specify Type) | | | |
| Kidney Problems (Specify Type) | | | |
| Stroke (Year) | | | |
| Thyroid Problems (Specify Type) | | | |
| Ulcers (Specify Type) | | | |
| OTHER | | | |

Mother's Date of Birth _____ Still living? Yes [] No []
Father's Date of Birth _____ Still living? Yes[] No[]

Previous **Surgeries** (*PLEASE SPECIFY-Right or Left*)_____
_____
_____

Previous **Foot or Ankle Surgeries** (*PLEASE SPECIFY-Right or Left)*_____
_____

Drink Alcohol? [ ] Yes [ ] No
Recreational Drugs[ ] Yes [ ] No
Drink Caffeine? [ ] Yes [ ] No
Do you exercise? [ ] Yes [ ] No

How often?_____
_____
Coffee, how many per day?_____Soda?_____
If yes, what exercise?_____
_____

**Please list all medications you are currently taking:** *(if you have a list we can copy and scan it)*

_____
_____
_____
_____
_____

**Please indicate drug allergies:** [ ] NONE
[ ] Penicillin [ ] Latex [ ] Sulfa [ ] Codeine [ ] Ace Inhibitors
[ ] NSAIDS [ ] Antibiotic Ointment [ ] Novacaine [ ] Lidocaine
[ ] Other _____

**Please describe the reason for your visit today: (Current Foot/Ankle Issue)**
[ ]RIGHT [ ] LEFT [ ] FOOT [ ] ANKLE

_____
_____
_____
_____

I acknowledge I have received a copy of a Notice of Privacy Practices from the office of Scott G Peters DPM, CWS. I hereby authorize release of any or all of my medical records as Dr Peters & Associates deem it necessary to improve the quality of my health care. I hereby authorize Dr Peters' office to submit Insurance claims to my insurance carrier(s) and release any information needed for the processing of claims related to medical services/supplies/devices provided. I hereby assign benefits for physician services to the Ankle & Foot Walk-In Clinic and Scott G Peters DPM CWS to administer such treatment and perform such procedures necessary or advisable in the diagnosis and treatment of the undersigned patient. **I understand that ultimately, I am financially responsible to Scott G Peters DPM CWS for any services not covered by my insurance carrier(s).** A copy of this signature is as valid as the original.

Initial :_____

**APPOINTMENT TIMES**: It is very important to be on time for your scheduled appointments. We are aware things do come up, emergencies on either end, however, we then get behind and causes delays for every other patient. We attempt to stay on schedule for every scheduled appointment. *If you are unable to be here on time-it is important to call us to let us know. If we have an opening that day we will try to fit you in or you will need to reschedule.*
**APPOINTMENT CANCELLATION POLICY: Appointments cancelled with less than 24 hour notice will require a $50.00 assessment fee.** I am aware of the appointment times and cancellation policy.

Initial :_____

# FINANCIAL POLICY

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is based on a contract between you and your insurance company.

**PATIENT BILLING**: You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. If payment is not received after a 60 day notice, your account will be forwarded to collections where additional fees will apply. Please let the billing office know if you have any difficulties resolving your bill as payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/Master Card/Discover. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

**SUPPLIES WE DISPENSE**: From time to time it is necessary for us to dispense durable medical equipment (DME) such as splints, braces, boots. The price we charge may be considerably higher than if you were to purchase them in the open market. Medicare developed a formula that takes into account a stocking fee, professional fitting and counseling on how to make proper use of these devices along with other variables and that is how they determine what we can receive as reimbursement.

**PRIVACY STATEMENT**: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**Assignment of Benefits**: I, undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Scott G Peters, DPM CWS office all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments 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 by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practice and understand and accept its terms. I have read the above policy regarding my financial responsibility to Scott G Peters DPM CWS office for medical services provided. I agree to pay Scott G Peters DPM CWS any balance unpaid by my insurance carrier for the above patient.

Signature_____Date_____