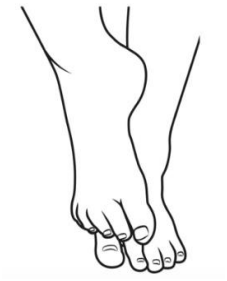

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NEW PATIENT PACKET

Date: _____

Patient Name: _____
First MI Last

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Gender: [ ] Male [ ] Female

Home Address: _____
City:_____ State:_____ Zip:_____

Contact Information

Email: _____

Primary phone number where we can reach you: [ ] Cell [ ] Home _____-_____-_____

Work _____-_____-_____ Additional number(s): _____-_____-_____

May we text you for appointment reminders? Yes [ ] No [ ]

Primary Language: _____ Race: _____ Ethnicity: _____

Emergency Contact: _____Number:_____-_____-_____

Primary Care Doctor: _____ Phone: _____-_____-_____

Pharmacy & Location: _____Phone:_____-_____-_____

Who is responsible for this payment: [ ] Self or [ ] Other (i.e. a spouse or parent)

Complete if 'Other' (*skip if 'Self'*): Guarantor's Relationship to Patient: _____

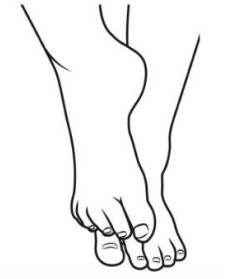
Guarantor's Name: _____

Guarantor's Date of Birth: _____/_____/_____ Guarantor's SSN (if known):_____-____-_____

Home Address: _____

City: _____ State: _____ Zip:_____

Whom may we thank for referring you to us? _____



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Primary Insurance Name: _____
Secondary Insurance: _____ [ ] I do not have secondary insurance
Tertiary Insurance: _____ [ ] I do not have tertiary insurance

Past Medical History

Allergies [ ] I have no known allergies

Medication Name What was your reaction? (i.e. rash)

_____

_____

_____

_____

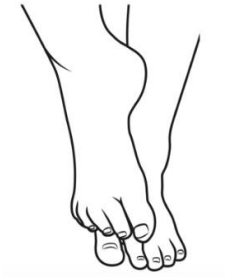
_____

Any allergic reaction to: [ ] Tape [ ] Latex [ ] Shellfish [ ] Iodine

Your Medical History

What medical condition(s) do you have / what condition(s) are you taking medication for? Please mark the appropriate column with an 'X.'

	Never Had	***Currently treated for***	***Prior history of***
Acid Reflux			
Anemia			
Arthritis **Type(s): _____**			
Blood Clots			
Bleeding disorder			
Cancer **Type: _____**			
Diabetes **Type: 1 or 2 (circle)**			
Depression			
Fibromyalgia			
Gout			
Heart Attack			
Heart Disease or Failure			



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Hepatitis Type: _____			
HIV / AIDS			
High blood pressure			
Kidney disease			
Liver disease			
Migraines or Headaches (circle)			
Peripheral neuropathy			
Polio			
Sickle Cell Disease			
Skin disorder			
Sleep apnea			
Stomach Ulcers			
Stroke			
Thyroid disease			

Any other conditions you are currently being treated for that are not listed above?

_____

_____

_____

Social History

Occupation: _____

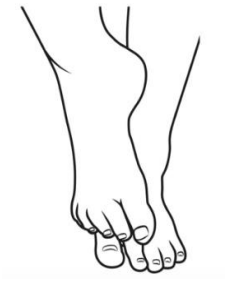
How active are you? [ ] Sedentary (< 20%) [ ] Mild (20-40%) [ ] Moderate (40-60%) [ ] Very (> 60%)

Are you: [ ] Single [ ] Married [ ] Partnered (in relationship) [ ] Divorced [ ] Separated [ ] Widowed

Do you drink? [ ] Never drank [ ] Former drinker, no longer drink [ ] Current drinker
If you drink, please quantify:
[ ] Light drinker (< 3 drinks/week) [ ] Moderate drinker (7-10 drinks) [ ] Heavy drinker (>10 drinks)

Have you ever smoked cigarettes or used tobacco? [ ] Never [ ] Current user [ ] Former Smoker
Current and former smokers:
How many packs per day? ____ How many years have you smoked? ____ years

Any drug (includes marijuana) use? [ ] Yes [ ] No [ ] Former drug use
If current or former, specify type and frequency:
Type: _____ [ ] Daily [ ] Weekly [ ] Monthly [ ] _____



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Family History

Any family history of:

[ ] Diabetes [ ] Type 1 [ ] Type 2 Which family member? _____
[ ] Bunions Which family member? _____
[ ] Flat feet [ ] High arches Which family member? _____
[ ] Cancer What type: _____ Which family member? _____
[ ] Heart disease [ ] Heart attack Which family member? _____
[ ] Arthritis What type: _____ Which family member? _____
[ ] High blood pressure Which family member? _____

Any other diseases running in your family not listed above?

_____

Your Surgical History [ ] Check if none

Surgery Approximate Date

_____

_____

_____

_____

_____

_____

_____

_____

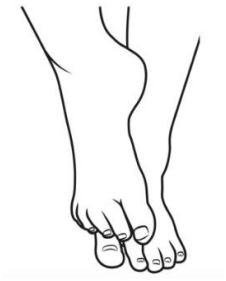
Current Medications (including herbal supplements and over the counter) [ ] Check if none

Name Dose How often (i.e. daily)

_____

_____

_____



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_____

_____

_____

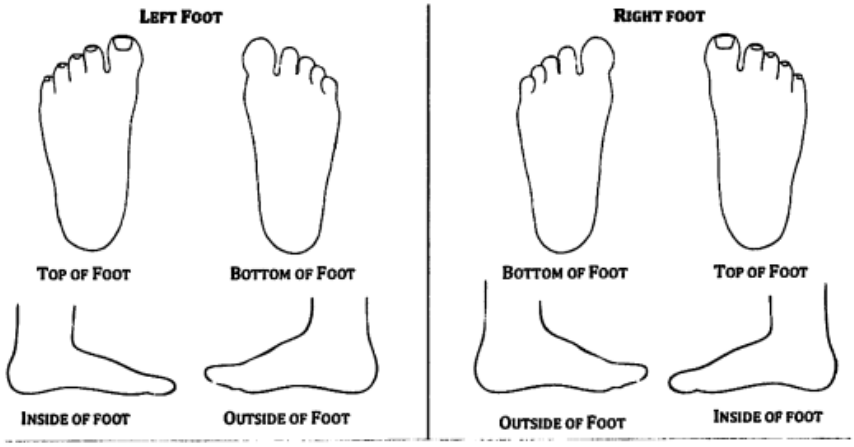
_____

_____

History of Present Illness

Shoe size: _____

Where is your pain located? (Please mark on the pictures below)



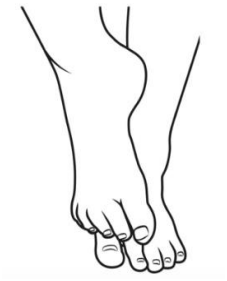
How long has this been going on? _____ Rate your pain on a scale of 1-10: _____

What words describe your pain? (circle all that apply) No pain Sharp Dull Aching Burning Itchy

Stabbing Like a ball or pebble Other: (please describe) _____

My pain has: [ ] Stayed the same [ ] Gotten worse [ ] Gotten better
What makes your pain feel better?_____
What makes your pain worse?_____
What treatments have you tried for this problem?_____

Was this problem caused by an injury, if so, how? _____
Work related injury? [ ] Yes [ ] No



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Review of Systems

Have you had any of the following? (check all that apply)

General [ ] Nausea [ ] Vomiting [ ] Fevers [ ] Chills [ ] Malaise (not feeling well)

Dermatologic [ ] Rashes [ ] Wounds or ulcers [ ] Psoriasis [ ] Dermatitis [ ] Skin cancer

Musculoskeletal [ ] Joint pain [ ] Muscle pain [ ] Implanted screws or plates or hardware

[ ] Broken bones (specify: _____)

[ ] Arthritis (specify type: _____)

[ ] None of the above

Any additional information about your medical history:

_____

_____

_____

_____

_____

_____

_____

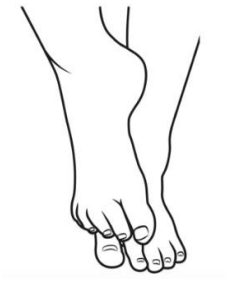
To the best of my knowledge I have answered the above questions on this form accurately. **I understand that providing incorrect information can result in adverse events or death.** I understand it is my responsibility to inform the doctor and the staff of any changes to my medical status.

_____ _____

[Signature] [Date]

_____ _____

[Print name of patient, parent, or guardian] [If other than patient, relationship to patient]



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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions please discuss them with our front office staff.

As a patient, **you are responsible for all authorizations & referrals** needed to seek treatment at this office. Unless other arrangements have been made in advance by you and your insurance carrier, payment for office services are due at the time of service.

Your insurance policy is a contract between you and your insurance company. We will file your insurance claim for you if you assign the benefits to the doctor. You agree to have your insurance company pay for the doctor directly. *If your insurance company doesn't pay the practice within a reasonable period, you are responsible for payment.*

We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans and will only require you to pay the copay, so insurance and deductible. If you have insurance coverage with a plan that we don't have prior agreement with, we will prepare to send the claim in for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, all charges for your care are due at the time of service.

All health plans are not the same, therefore all coverage is not the same. In the event coverage is not available for a service, you will be responsible for that charge. It is your responsibility to inform office staff of all insurance changes and referral/authorization requirements. You will be responsible for any charges denied.

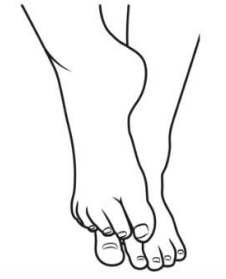
There are certain elective surgical procedures for which we will require prepayment. You will be informed in advance. Payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All costs insured doing this process will be your responsibility in addition to the balance owed to the practice.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Requests to "write off" charges for services performed will not be honored. Any disputes over charges should be submitted to the office manager. Each case will be reviewed by the physicians and a resolution will be determined.

I have read the above financial policy and will agree to abide by it. Initials: _____



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No Show Policy

As a courtesy, we require 24 hours' notice for cancelling appointments and 1 weeks' notice for cancelling surgeries. We do not accept voicemail requests to cancel appointments. You must speak with a staff member in person to cancel or reschedule.

An appointment is considered a "No Show" if:

1. You do not show up for your appointment at the scheduled time.
2. You cancel with less than 24 hours' notice (for office visits or procedures).
3. You cancel with less than 1 weeks' notice (for surgeries).

If your insurance (i.e. Medicaid) does not allow no show fees, you are exempt from no show fees, however, **2 or more no shows are grounds for dismissal from the practice.**

All other patients are subject to the no show fees, as follows:

Procedure No Show Fee (i.e. ingrown toenails)	**$75-$100 (depending on time allotted)**
First No Show Fee	$25-$50
Second No Show Fee	$50-$75
Subsequent No Show Fee	$75
Surgery No Show Fee	$200

All surgery no show fees must be paid in full prior to staff rebooking the surgery.

I have read the above no show policy and will agree to abide by it. Initials: _____