CENTRAL FOOT AND ANKLE ASSOCIATES, PA

Linda Nachmani, DPM

Patient:_____
Last name First name Middle Initial
Responsible Party (If a minor):_____
Street Address _____City:_____ State_____ Zip _____
Home Phone: _____ **Cell Phone:**_____
Is it ok to leave medical information on Phone message? (Yes / No) Which phone number? _____
Email Address: _____ OK to contact you via e-mail? (Yes / No)
Social Security:_____ **Birth date**: _____ **Age**:_____ Sex: M F
Martial Status: Single Married Widowed Separated Divorced
Employer:_____ Work Phone:_____ Position/Occupation:_____
Emergency Contact Name:_____ Phone:_____
Primary Care Physician:_____ Phone:_____
Preferred Pharmacy: _____ Phone:_____

How did you hear about our practice? (circle one)
Internet/Google Friend/Family Insurance Company ZocDoc Facebook Other:_____
Doctor Referral (who)?_____

INSURANCE INFORMATION:
Primary Insurance:_____ ID#_____ Group#_____
Street Address:_____ City:_____ ST:_____ Zip:_____
Subscriber's Name (if not patient):_____ Relationship to patient:_____
Social Security: _____ Birth date: _____
Customer/Member Services Phone Number: _____
Secondary Insurance:_____ ID#_____ Group#_____
Street Address:_____ City:_____ ST:_____ Zip:_____
Subscriber's Name (if not patient):_____ Relationship to patient:_____
Social Security: _____ Birth date: _____
Customer/Member Services Phone Number: _____

Please provide your identification and insurance card(s) to the receptionist to be copied

ASSIGNMENT AND RELEASE:
My signature below authorizes my doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due me be payable directly to my physicians. I understand that I will be responsible for any remaining balance that I have on my account, in addition to the amount due at the time of service.

_____ _____
Patient's or Responsible Party's Signature Date

_____ _____

Age Date:

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Patient:_____

Last name First name Middle Initial

Shoe Size:_____ Weight: _____ Height: _____

HISTORY OF PRESENT ILLNESS: (Please Circle all that apply)

1. Reason for today's visit? _____
2. How Long has this been going on? _____
3. What part of the foot/ankle is the pain/condition located? **Foot / Ankle Left / Right Both**
4. Severity of pain or condition? **Mild Moderate Severe Severe at times**
5. Type of pain? **Sharp Dull Stabbing Aching Burning Other**
6. How would you rate your pain on a scale from 0 to 10? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
7. What makes it worse? **Activity Exercise Work Laying in Bed Other**
8. What makes it better? **Rest Ice Heat Elevation Other**
9. What treatments have you tried, if any?_____
10. Do you wear custom Orthotics? **Yes / No**

ALLERGIES:

Are you allergic or sensitive to any of the following? (Please Circle)
Aspirin Codeine Iodine Latex Metals Morphine Neosporin Novocain Penicillin Shellfish Sulfa Tape **No Known Allergies**
Other: _____

CURRENT MEDICATIONS: (Include over-the-counter and supplements)

Medication	Dosage	Medication	Dosage

Did you receive a Flu Vaccine? Yes / No Month_____ Year_____

Did you receive a Pneumonia Vaccine? Yes / No Month_____ Year_____

PAST MEDICAL HISTORY: (Please Circle all that apply)

Acid Reflex	Asthma	Bleeding tendencies	Bronchitis/Emphysema
Fibromyalgia	Heart disease/failure	High blood pressure	High Cholesterol
Neuropathy	Polio	Skin disorder	Low blood pressure
Anemia	Back trouble	Blood clots	Stroke
Gout	Hepatitis	Kidney disease	Cancer
Open sores	Rheumatic fever	Sleep Apnea	Migraine headaches
Arthritis	Bladder infections	Blood transfusion	Thyroid disease
Heart Attack	HIV + or AIDS	Liver disease	Diabetes
Pneumonia	Sickle cell disease	Stomach ulcers	Mitral valve prolapse
			Tuberculosis

PAST SURGICAL HISTORY: (List all procedures and hospitalizations you have had, include date and year)

Procedure	Date	Procedure	Date

FAMILY HISTORY: (Please list all medical conditions that run in your immediate family)

Mother: Alive / Deceased medical conditions: _____

_____

Father: Alive / Deceased medical conditions: _____

_____

SOCIAL HISTORY: (Please Circle all that apply)

Use of alcohol: Never Rare Occasional Moderate Daily Previous alcohol abuse

Do you use tobacco? Yes / No Type: _____ Quantity: _____ Quit Date: _____

Do you use drugs? Yes /No Type/Frequency: _____ Quit Date: _____

How much of the day do you spend on your feet? 25% 50% 75% 100%

What type of exercise do you do regularly? _____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____

Print Name of Patient, Parent or Guardian Signature of Patient, Parent or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (If Applicable)

_____

Signature

CENTRAL FOOT AND ANKLE ASSOCIATES, PA
Linda Nachmani, DPM

OFFICE POLICY

Welcome to our office, our goal is to provide the best podiatric care available for each of our patients. Charges for services are what we determine to be usual and customary fees for the professional services provided. We will be happy to provide all necessary information for any insurance claims related to treatment or surgery rendered in our office and/or surgical facility. However, due to the many varieties of insurance plans available we have no way of determining what the insurance plan coverage will be in each individual case.

We will verify your coverage prior to your visit however, the information given is not a guaranty of payment and payment is subject to the terms, conditions and limitations of each patients plan. It is your responsibility to know and understand your coverage and benefits. Any differences in services covered and those your insurance actually paid for are your responsibility.

You will be responsible for contacting the insurance company to dispute the difference. Insurance claims must be paid in a timely manner, all claims that have not been paid in 90 days due to dispute may become your responsibility. All accounts past due more than 60 days will be sent to collections, No Exceptions.

The federal government has informed us that we can be prosecuted for not collecting the co-payment. Therefore, co-payments and /or deductible will be collected before services are rendered. Insurance company may require pre-certification, pre-determination or a second opinion. X-rays or other necessary records will be provided for your convenience; however 1-2 weeks' notice is required for duplication. Our office charges a medical records duplication fee of $40 for records. This must be paid prior to records being duplicated.

I have read and understand the office policy. If you have any questions regarding fees, professional services, or individual problems please feel free to bring them to our attention.

Thank you for your cooperation

Patient Signature: _____
Date: _____

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APPOINTMENT CANCELLATION/NO SHOW POLICY

Our goal is to provide quality individualized medical care in a timely manner. “No Shows” and late cancellations inconvenience those individuals who are in need of medical treatment. We would like to remind you of our office policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please call CFAA promptly if you need to cancel or reschedule your appointment. We require that you call twenty-four (24) hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to receive medical care in a timely manner.

No Show Policy

A “No Show” is someone who is not present at the time of their scheduled appointment and has not provided adequate notification. We understand that emergencies may occur, however, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment.

Charge for Late Cancellations and No Shows

Failure to give a 24 hour advance cancellation or being a “No Show” will result in a nonrefundable administrative charge of $40.00. This fee will not be covered by your insurance company.

If you have any questions regarding this policy, please ask our staff and we will be glad to clarify your questions. We thank you in advance for your cooperation and understanding.

I acknowledge that I have been presented with the Appointment Cancellation/No Show Policy and that I understand the Policy.

_____	_____	_____
Print Name of Patient	Signature of Patient/Guardian	Date

Greenway
2900 Weslayan Street Ste. 650
Houston, TX 77027

Pearland
10905 Memorial Hermann Drive Ste. 211
Pearland, TX 77584