Keystone Podiatry Clinic- New Patient History

(Specialists in Foot & Ankle Surgery)

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Thank you for choosing Keystone Podiatry Clinic for your foot and ankle care!

So that we can provide you with the best possible care, please take a few minutes to complete this form. Please tell us about your health and what you would like to accomplish during your visit. The information provided will help us get to know you and ensure that all your questions and concerns are addressed.

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Name: _____ **DOB** _____

1. What is the **reason** for today's visit?

   _____

   _____

2. **How long have you had this problem?** _____

3. **What do you think caused this problem?** _____
   Was there an injury? (when?) _____

4. **Please circle treatment that you have tried:**

Ice/Heat	Stretching	Decrease Activity	Physical Therapy	New Shoes
Injections	Prescription Medication	OTC Medication	Prescription Arch supports	OTC Arch supports
Surgery	No past treatment	Other:		

5. **Please rate your pain on a scale of 0-10.** (0 is no pain and 10 is the worst pain ever) _____

6. **Have you had recent X-rays, MRI or other imaging tests of your foot or ankle?**

   _____

7. **Are you a current smoker?** _____ **Do you have a history of smoking?** _____

8. **Past/current medical history (Circle all that Apply)**

Diabetes (controlled by insulin/pills/diet)	Bladder/Kidney/urinary trouble
High Blood Pressure/Stroke	Parkinson's/Alzheimer's
Heart Attack/leaky valve	Headaches/depression/anxiety
Irregular heartbeat/congestive heart failure)	Skin trouble/rashes
High cholesterol	Leg/foot sores/ulcer
Cancer (type)	Dentures/glasses
Epilepsy	Thyroid Disease
Osteoarthritis/rheumatoid arthritis	Joint Replacement – Joint(s)-
Degenerative joint disease/gout	Bleeding problems/anemia
Poor circulation/varicose veins	Blood Clots
Cirrhosis/Hepatitis	Slow wound healing
Asthma/bronchitis/COPD	Hay fever/allergies
Stomach/bowel problems	Surgical Complications:

9. **Please circle if family members have any of the following medical conditions:**

Diabetes	High Blood Pressure/Stroke	Rheumatoid Arthritis
Blood Clots	Osteoporosis	Bleeding Disorder
Foot Problems	Other:	No related family history

10. **Please list your current medications or provide a list:**

_____

_____

11. **Are you allergic to any Medications, Iodine, or Material (Latex etc.)? Yes _____ No _____**
List allergy / reaction: _____

12. **Please list past surgeries with approximate date:**

_____

_____

13. **Your current Height:** _____ **Weight:** _____ **Shoe Size:** _____

14. **What Pharmacy do you use?** _____

15. **Who is your Medical Doctor?** _____

I certify that the above information is true and accurate to the best of my knowledge. I give permission to Keystone Podiatry Clinic to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my condition.

Please sign _____ **Date** _____

Keystone Podiatry Clinic

2714 Mercer Road
New Castle, Pennsylvania 16105

PATIENT FINANCIAL AGREEMENT & ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF RRIVACY PRACTICES

I hereby authorize Keystone Podiatry Clinic to apply for benefits on my behalf for services rendered. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company to determine these benefits payable. I request that payment of authorized benefits be made payable to Keystone Podiatry Clinic on my behalf.

- ✓ **We participate with most insurances, however, there are a few that we are not in-network with. Please confirm with your insurance company that we are listed as participating providers. By contract, covered charges will be paid directly to us by your insurance company. Any applicable co-payments are due at the time of service. You will also be responsible for any co-insurance or deductible amounts that are applied by your insurance company.**

- ✓ **If we do not participate with your insurance, you will be required to pay in full for charges at the time of service or a reasonable payment plan will be arranged. As a courtesy, we will submit the insurance form on your behalf requesting that payment by made directly to you for reimbursement.**

- ✓ **A fee will be charged to all patients for any returned checks. The charges may vary and will only be the amount that was charged to us by your financial institution.**

- ✓ **If a referral is required for treatment by your insurance company, it is your responsibility to obtain the referral from your PCP. If a referral is not received, you may be charged for the treatment received for that visit.**

- ✓ **I understand that I am financially responsible for any non-covered and/or denied charges incurred on my behalf.**

- ✓ **I acknowledge that I was provided a copy of Keystone Podiatry Clinic's Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the Notice.**

- ✓ **A copy of this agreement may be used in place of the original.**

Keystone Podiatry Clinic may disclose my PHI (which includes information about my health or condition and the treatment provided to me) to the following person/persons:

Name: _____ **Relationship:** _____

PRINT NAME _____

SIGNATURE _____ **DATE** _____