MASTRACCO FOOT & ANKLE

## Patient Information

Last Name_____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Date of birth _____ Age _____ Sex: Female or Male (Circle One)

| Primary Phone number: | Secondary Phone number: | Work Phone number: |
|---|---|---|
| _____-_____-_____ | _____-_____-_____ | _____-_____-_____ |

Social Security Number: _____

Please check one: ____Married ____Single ____Widowed ____Separated ____Divorced ____Minor

Employer _____ Occupation _____

Email Address _____

| Emergency Contact first and last name: | Emergency Contact phone number: | Emergency contact relationship to patient: |
|---|---|---|
| _____ | _____ | _____ |

Responsible party name and date of birth (Primary Insurance Holder): _____
How are they related to the patient?: ____ Self ____Spouse ____Parent ____Other
If other, please list: _____

Primary care physician first and last name: _____

Preferred pharmacy name: _____

Pharmacy address:_____

# Medical History

Current health condition (Why are you here?): _____

Have you seen another physician for this issue? (Podiatrist or other): YES or NO (circle one)

If YES, please list physicians name here: _____

| Height: | Weight: | Shoe size: |
|---|---|---|
| _____ | _____ | _____ |

Do you exercise or participate in athletic activities? YES or NO (circle one)

If YES, how many times per week? _____

If YES, what type of activities? _____

Do you use tobacco products? YES or NO (circle one)

If YES, what type? _____

For how long? _____

Below, please circle any issues you are currently having and ones that you have had in the past:

| | | |
|---|---|---|
| Ankle Pain | AIDS/HIV | Fainting |
| Athlete's foot | Allergies | Headaches |
| Bunions | Anemia | Heart attack |
| Corns and Calluses | Angina | Heart disease |
| Cramps in feet | Arthritis | Hypothyroidism |
| Foot pain | Artificial joints | Hyperthyroidism |
| Gout | Artificial heart valve | Hepatitis B |
| Numbness in feet | Asthma | Hepatitis C |
| Flat feet | Anxiety | Implanted metal hardware |
| Heel pain | Alcohol Dependency | High blood pressure |
| Ingrown toenails | Back pain | Low blood pressure |
| Plantar warts | Bleeding disorder | Kidney failure |
| Swelling in feet | Blood clots | Liver disease |
| Swelling in ankles | Bronchitis | Lung disease |
| Foot ulcers | Cancer | Metal removed from the eyes |
| | Chemical Dependency | Neuropathy |
| | Circulatory problems | Osteoporosis |
| | COPD | Pace Maker |
| | Diabetes | Phlebitis |
| | Depression | Pneumonia |
| | Elevated Cholesterol | Psychiatric care |
| | Ear problems | Radiation treatment |
| | Epilepsy | Shortness of breath |
| | Eye problems | Stroke |
| | | Varicose veins |
| | | Vitamin D Deficiency |

## Medical History Cont.

**If there are other health conditions that Dr.Mastracco and our team need to know about, please list here:**

_____

**Do you have a family history of diabetes?**

**YES or NO (circle one)**

**Have you been hospitalized in the last 5 years? YES or NO (circle one)**

**If yes, what for and for and when?**

_____

**Please list any surgeries you have had and the date of the operation:**

_____

_____

**Age 65 or older, have you fallen in the past year? YES or NO (circle one)**
**If yes, when?** _____

## Medications and Allergies

**Please list all <u>current medications</u>, with <u>dosages</u>, that you are currently taking below. If you carry a list, please have our office staff make a copy:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Are you <u>allergic</u> to any of the following? (please circle)**

**Adhesive/Tape**
**Aspirin**
**Pain Medications**
**Iodine**
**Anesthesia**
**Sulfa drugs**
**Penicillin**
**Anticoagulant therapy**
**Codeine**
**Demerol**
**Local Anesthetics**
**Novocain**
**Seafoods**

**Please list any other allergies here:**

_____

_____

**Please check this box if you have NO KNOW DRUG ALLERGIES**

☐

## Consent for Treatment

I give my consent for necessary medical and surgical treatment, and the use of anesthetics or any medications deemed necessary for my care.

## Insurance Authorization

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

**Medicare**

I request that payment of the authorized Medicare benefits be made on my behalf to MASTRACCO FOOT & ANKLE for any services furnished about me be that physician. I authorize any holder of medical information about me to be released to the benefits payable for related services.

I hereby authorize Medicare to furnish MASTRACCO FOOT & ANKLE any information regarding me Medicare claims under Title XVII of the Social Security Act.

**Commercial Insurance**

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

The sheer volume of paper work and phone calls that are now being thrust upon physician's offices have become incredible. This particular office deals with over 200 insurance companies and therefore it is impossible to memorize each and every insurance plan. As a service to you, our office will gladly submit any covered visits or procedures to your insurance company. After a 30 day period we will inquire as to the status of all unpaid claims. Again in 30 days, an inquiry will be made. If at any time we have no results from the insurance company, the account will then be payable by the patient. It is the patient's ultimate responsibility to be aware of their insurance plan. Many insurance plans require patients to obtain referrals from their Primary Care Physician to use particular labs, hospitals, etc. You as the subscriber are responsible for your policy. We are trying to avoid confusion and financial hardships on you. Thank you for your attention and understanding.

## Notice of Privacy Policies

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third party payers; and/or (3) conduct normal healthcare operations such as the quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I also understand that I make revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**I HAVE READ THE ABOVE AND I ACCEPT: CONSENT FOR TREATMENT, INSURANCE AUTHORIZATION, AND NOTICES OF PRIVACY POLICIES.**

**SIGNATURE:** _____ **Today's Date:** / /

**Relationship to patient being treated today (circle one): SELF OTHER (if other, how are you related?):** _____