New Patient Welcome Forms

Name: _____ Date of Birth: _____Age:____

Address: _____
Street Apt. # City State Zip

SSN: _____-____-_____ Sex: MALE or FEMALE Email:_____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

How were you referred to our office? _____

Preferred Pharmacy Name and Location: _____

Pharmacy Phone Number: ( )_____

Primary Care Physician (Family Doctor): _____

Date of Last Visit: _____ Physician Phone Number: ( )_____

Emergency Contact Information

Name: _____ Relationship:_____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Insurance Responsible Party

Name: _____ Date of Birth:_____ Relationship:_____

Address: _____
Street Apt. # City State Zip

SSN: _____-____-_____ Sex: MALE or FEMALE

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Employer: _____ Employer Phone: ( )_____

Patient Name: _____ DOB: _____

Demographic Update

1. Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

Please circle one: YES or NO

2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check all that apply.

___ American Indian or Alaskan Native
___ Asian
___ Black or African American
___ Native Hawaiian or other Pacific Islander
___ White or Caucasian
___ I wish to decline answering questions 1 and 2 regarding race and ethnicity

3. What is your primary language?

___ English ___ Other, please specify: _____

4. (Regardless of your answer to question 3) Do you need an interpreter?

Please Circle One: YES or NO

Patient Name: _____ DOB: _____

Reason for Visiting

*Please answer the following questions to help our staff provide you with the best quality treatment.

Describe your problem:

_____

When did the problem start? (Please give a date or rough estimate. Example: one week ago)

_____

Shortly describe how the problem started:

_____

How painful is your condition? (Scale: 0 = no pain 10 = extremely painful)

Please circle one: 1 2 3 4 5 6 7 8 9 10

Please check all that apply:

Type of pain: __Burning __Tingling __Sharp __Dull Ache
__Shooting __Stabbing __Numbness __Throbbing

When does the pain occur?

__Standing __During walking __After walking
__During sports __Worse with activity __Better as activity continues
__With shoes __Without shoes __A.M. __P.M.
__Lying in bed __Always

Have you received treatment for this problem? YES or NO
If yes, please describe the treatment: _____
_____
_____

Total Healing Wound Center

Patient's Name: _____ DOB:_____

Medical History

Patient Height: ____ft _____in Patient Weight: _____lbs
Blood Pressure: _____ / _____ Shoe Size: _____

Medication	Dosage	Medication	Dosage

*Please continue on the back of the sheet if you need more space.

Allergies (Please check ALL of the patient's allergies)

__ NONE __Penicillin __Sulfa __Iodine/Shellfish __Aspirin __Anesthetics __Latex

__Codeine __Adhesives __Cortisone __Environmental Other:_____

Surgical History

Procedure	Year	Any Complications?

Family History

*Please check all that apply, or write in	Father	Mother	Brother	Sister
Arthritis				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke/Heart Attack				
Kidney or Liver Disease				
Rheumatic Conditions				
Bleeding Disorders				
Cancer (List Type)				
Other:				

Total Healing Wound Center

Patient's Name: _____ DOB:_____

Health History

* Please check any of the following current or past conditions you may have, and list any major health concerns

__Diabetes: Please cirlce your type: Type 1 or Type 2 What was your last reading?_____
Who is managing your diabetes?
Doctor's Name:_____ Phone: ( )_____

__Anemia	__Deep Vein Thrombosis	__Epilepsy	__Nerve Conditions
__Heart Disease	__Arthritis	__Tuberculosis (TB)	__High Blood Pressure
__Osteoarthritis	__Stomach Ulcers	__Skin Disorder	__Tuberculosis
__Venous Stasis	__Aids (HIV)	__Lung Disorder	__Kidney Disorder
__Stroke	__Hepatitis	__Osteoporosis	__Bleeding Problems
__Colitis/Chron's	__Poor Circulation	__Gout	__Asthma/COPD
__Joint Pain	__Thyroid Disorder	__Rheumatic Fever	__Acid Relux/GERD
__High Cholesterol	__Coronary Artery Disease	__Multiple Sclerosis	__Mitral Valve Prolapse
__Recurrent Infections	__Eczema	__Muscle Weakness	__Broken Bones
__Speech Difficulties	__Deaf/Hearing Loss	__Neuropathy	__Seizures
__Prostate Disorder	__Chest Pains	__Congestive Heart Failure	
__Leg Pains	__Rheumatic Conditions	__Swelling of feet/ankles	
__Shortness of Breath	__Ataxia (Loss of Balance)	__Multiple Sclerosis (MS)	
__Peripheral Arterial Disease		__Peripheral Vascular Disease	
__Psychiatric Disorder:_____		__Cancer:_____	

__Other Major Health Concerns:_____

Social History

1. Do you smoke tobacco? ___Yes ___No
   If Yes: #packs per day?_____ #cigarettes per day?_____ #of years?_____
   If No: Did you ever smoke? ____Yes ____No
2. Do you drink caffeine (teas, coffee, soda/pop)? ____Yes ____No

If yes, how many per day? ___1-2 ___3-5 ___6-9 ___10 or more

3. Do you consume alcohol? ____Yes ____No

If yes, how much?: ____Socially/Rarely ____Occassionally ____Daily ____Recovering

4. Are you employed? ___Yes ___No
   Employer:_____

***Any type of drug use is a personal choice and WILL IN NO WAY adversely affect your relationship with the doctor.**

However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Do you use recreational drugs? ___Yes ___No

If yes, what substance(s) and how often?_____

To the best of my knowledge, the questions in this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and interfere with my treatment.

Patient/Guardian Signature:_____

Notice of Privacy Practices

Acknowledgement of Receipt

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 chose) and understood the Notice.**

Print Patient Name:_____ **DOB:** _____

Patient Signature:_____ **Date:**_____

Parent or Authorized Representative (if applicable): _____

**** Packets are available at the front desk.**

Total Healing Wound Center

HIPPA Compliance

Please answer for HIPPA compliance: May we leave appointment reminders and procedure dates on your home answering machine, cell phone, or other voice communication device voicemail?

Please Circle One: YES or NO

Patient Signature: _____ DOB: _____

Date: _____

If the patient is unavailable, do you authorize us to share health information with anyone else?
Please Circle One: YES or NO

Please list authorized personnel:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Total Healing Wound Center of any changes to the above information.

Patient or Guardian Signature: _____ Date: _____

Financial Policy and Responsibility

Thank you for choosing Total Healing Wound Center to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive may imply a financial responsibility on your part.

Insurance: We participate in most insurance plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your medical health coverage. If you are not insured by a plan we participate with, full payment for services is expected at each visit. If you are insured by a plan we participate with but do not have a current insurance card, payment in full for each visit is required until your coverage is verified.
Medicare: We are a participating Medicare provider. Medicare, as well as any applicable secondary insurance, will be billed for you. There is no guarantee of service coverage. Patients are responsible for paying their annual deductible if it has not been met. Patients are also responsible for any co-payments. Copayment is typically 20% of the allowed item or service price.
Secondary Insurance: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.
Copayments and Deductibles: All co-payments and deductible payments must be paid at the time of service. Your insurance company contracts this arrangement. Failure to collect such payments can be considered fraud. Please help us uphold the law by paying your co-payment at each service visit.
Self-Pay: If you do not have health insurance, full payment for services is due at the time of service.
Non-covered Services: Please be aware that some of the services available at our practice may not be covered by your insurance. Your insurance has the power to deem some medical services unnecessary for your health. If you chose to receive these services, you are responsible for payment.
Referrals/Authorizations: We are required to follow the guidelines of your managed health care plan that may mandate us to require referrals from your primary care physician to see a specialist. If your insurance requires a referral from your primary care physician, it is your responsibility to get a referral from your primary care physician.
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 your insurance company's request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays the claim or not. Your insurance coverage is a contract between you and your insurance company.
Patient Billing: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and final notice, your account will be forwarded to collections. Please contact our billing office if you have any difficulties receiving or paying your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: cash, check, or VISA/MasterCard/Discover credit card. An additional $25.00 will be added to your statement if your check is returned for insufficient funds. In the event that your insurance company send payment to you (the patient), we require payment be forwarded to our office to be applied to the account balance.
Privacy Statement: Any information disclosed in your records will remain confidential and will not be used for any other reason outside of providing you quality care and treatment. Your information might aso be used to submit claims to your insurance company and contact you as needed.
Assignment of Benefits: I certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Columbus Podiatry & Surgery Inc. dba Total Healing Wound Center, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MY MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.
Missed Appointments: Our policy is to charge $25.00 for missed appointments. Missed appointments are considered those not cancelled at least 24 hours in advance to the scheduled appointment. These charged will be your responsibility and billed directly to you. Please help us serve you better by knowing your scheduled appointment date and time.

I understand that it is my responsibility to inform Total Healing Wound Center of any changes in my health insurance information. I have read the above policy regarding my *financial responsibility* to Total Healing Wound Center for medical services provided. I agree to pay Total Healing Wound Center any balance unpaid by my insurance carrier for the signed patient.

Print Patient Name: _____ Signature: _____

Print Patient Guardian: _____ Signature: _____