PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State, Zip Code:**
Physical Address (If Different from Above)**:**	**City:**	**State, Zip Code:**
Birth Date:	**Age:**	**Sex:**
Home Phone #:	**Cell Phone #:**	**Work Phone #:**
Preferred Method of Contact (Circle One)**:** **VOICEMAIL TEXT EMAIL**	**If Text or Voicemail, which # is preferred?**	**Email:**
Social Security #:	**Marital Status:**	**Employer:**
Ethnicity (Circle One)**:** **HISPANIC/LATIN** **NOT HISPANIC/LATIN** **REFUSE TO STATE**	**Race:**	**Pharmacy:**

Primary Care Physician:	**Referred By:**

Whom may we contact for future information if you CANNOT be reached?

_____ _____ _____

(Name) **(Phone #)** **(Relationship to Patient)**

Do you have an Advanced Directive? YES/NO –(Living Will, Do Not Resuscitate, Surrogate Care, Power of Attorney)

INSURANCE INFORMATION

(Please give your insurance card to receptionist)

Primary Insurance (Just Name of Insurance)**:**	
Subscriber's Name/ Date of Birth:	**Relationship to Patient:** (Circle one) **SELF / SPOUSE / CHILD / OTHER:**
Secondary Insurance (Just Name of Insurance)**:**	
Subscriber's Name/ Date of Birth:	**Relationship to Patient:** (Circle one) **SELF / SPOUSE / CHILD / OTHER:**
Patient Signature:	**Date:**

FOOT HEALTH INFORMATION:

What is your current foot/ankle problem? (Be specific): _____

_____Right/ Left/ Both

When did it begin? _____

Is this related to a Motor Vehicle Accident or Worker's Compensation Claim? _____YES _____NO

How have you treated this problem so far?

_____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

Shoe Size: _____ Height: _____ Weight: _____

MEDICATIONS: NONE

	Medication Name	**Dose**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

MEDICAL HISTORY: (Circle all that apply) **NONE**

Major Disease:
Diabetes I / Diabetes II
(Insulin / Non-Insulin)
High Blood Pressure
High Cholesterol
Bleeding Disorder
Heart Attack
Stroke
Cancer
Hepatitis
Thyroid Problems
Liver Disease
Gout
HIV
Kidney Disease/ Dialysis

HEENT:
Headaches
Blurred Vision
Double Vision
Hearing Loss

Respiratory:
Lung Disease
Shortness of Breath
Asthma

Psychological:
Anxiety
Depression

Vascular:
Varicose Veins
Poor Circulation
Night Cramps
Leg Ulcers
Blood Clots

Arthritis:
Back Pain
Joint Pain
Pain in Hands
Pain in Feet

Gastrointestinal:
Nausea
Vomiting
Ulcers

Podiatric Conditions:
Corns/Calluses
Numbness in Feet
Bunions
Night Cramps
Heel Pain

Other: _____
_____

ALLERGIES: (Please circle all that apply and **list the type of reaction** you have) **NONE**

Penicillamine:_____
Novocain:_____
Codeine:_____
Adhesive Tape:_____
Sulfur Drugs:_____
Iodine:_____
Latex Gloves:_____
Other:_____

PREVIOUS SURGERIES & DATES: NONE

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS HOSPITALIZATIONS & DATES: NONE

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY: (Circle all that apply) **NONE**

Does your **Mother** have a history of: **ALIVE** **DECEASED** **UNKNOWN**
1. Diabetes 2. High Blood Pressure 3. Heart Disease 4. Stroke 5. Cancer 6. Other:_____

Does your **Father** have a history of: **ALIVE** **DECEASED** **UNKNOWN**
1. Diabetes 2. High Blood Pressure 3. Heart Disease 4. Stroke 5. Cancer 6. Other:_____

Does your **Brother** have a history of: **ALIVE** **DECEASED** **UNKNOWN**
1. Diabetes 2. High Blood Pressure 3. Heart Disease 4. Stroke 5. Cancer 6. Other:_____

Does your **Sister** have a history of: **ALIVE** **DECEASED** **UNKNOWN**
1. Diabetes 2. High Blood Pressure 3. Heart Disease 4. Stroke 5. Cancer 6. Other:_____

TOBACCO USE/ SMOKING: (Circle **all** that applies)

1. **Non-Smoker**
2. **Current smoker:**
   - **How Often:** Every day , Some days
   - **How Many Cigarettes:** 5 or less , 6-10 , 11-20 , 21-30 , 31 or more
3. **Former Smoker:**
   - **How long has it been since you last smoked? _____**
   -

DRUGS/ ALCOHOL:

Have you ever used recreational drugs? (Circle **one** that applies)

- No
- Currently use marijuana
- Currently use meth/amphetamines/cocaine/narcotics
- Do not currently use but have a history of drug use

Do you regularly drink alcohol? (Circle **one** that applies)

- No
- Occasionally
- Daily

ASSIGNMENT/ RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign to Maui Family Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and I may be billed for additional costs incurred in the collection of these accounts. I understand that it is my responsibility to know and understand my insurance plan. I hereby authorize Maui Family Foot Care's office to release any private health information necessary in treatment, payment or health care operations. I authorize the use of this signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so. *I authorize Maui Family Foot Care to view my external prescription history via our RxHub service*. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I certify that the information I have provided Maui Family Foot Care's office is true and correct to the best of my knowledge. *I give permission to Maui Family Foot Care and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment on this visit as well as subsequent visits.*

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

MAUI FAMILY FOOTCARE FINANCIAL POLICY – effective 02/2017

Maui Family Footcare strives to provide you with the very best healthcare possible. Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions regarding this policy, please discuss them with our front office staff or supervisor.

- **PICTURE ID AND INSURANCE CARD(S) MUST BE PRESENTED AT INTIAL VISIT. IF NOT PRESENT, YOU WILL NEED TO RESCHEDULE APPOINTMENT.**

- Payment for office services are due at the time of service. We accept Visa, Mastercard, American Express, Care Credit, cash or check. There is a service fee of $25 on all returned checks.

- 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 Maui Family Footcare. In other words, you agree to have your insurance company pay Maui Family Footcare directly. If your insurance company does not pay the practice within a 90 (ninety) day period, we will have to look to you for payment.

- As our patient, you are responsible for all authorizations/referrals needed to see treatment in this office. Our staff is here to assist you, but understanding your policy benefits as well as limitations remains your responsibility.

- We participate with several insurance plans to accept an assignment of benefits. We will bill the plans we participate with and you will be responsible for any co-payments/co-insurances and deductibles.

- If you have an insurance plan we do not participate with, we will provide a claim to you, which you may submit to your carrier on an unassigned basis. This means your insurance plan will send the payment directly to you. Therefore, all charges for treatment are due at the time of service. We do not participate with Worker's Compensation, Motor Vehicle Accident or Third-Party liability claims.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "non-covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for specialized services or referrals; however, you remain responsible for any services rendered at our office. Patients are encouraged to contact their insurance plans for clarification of benefits prior to services rendered.

- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- Past due accounts (greater than 90 days) are subject to collection proceedings. All costs incurred including, but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- Please allow 48 hours for medication refill.

Printed name of Patient/Responsible Party_____Pt intials rec/waived copy_____

Signature of Patient/Responsible Party:_____Date:_____

MAUI FAMILY FOOTCARE – CANCELLATION, NO SHOW AND LATE ARRIVAL POLICY

Maui Family Footcare strives to provide excellent individualized medical care in a timely manner. We make every effort to maintain appointment times.

CANCELLED APPOINTMENTS: We understand that situations arise in which you must cancel your appointment. It is requested that if you must cancel your appointment, you provide our office 24 hour notice. Appointments which are cancelled with less than 24 hours will be subject to a **$35.00 cancellation fee.**

NO SHOWS: Patients who do not show up for their appointment without a call to cancel the appointment will be considered a **NO SHOW** and will be subject to a **$50.00 no show fee**. Patients who no-show three (3) or more times in a 12 month period may be dismissed from the practice and denied future appointments.

LATE ARRIVALS: If you are running late, please call the office. Patients who arrive more than 15 minutes late for their scheduled appointment will need to reschedule.

Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment

We understand special circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

PLEASE SIGN THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THIS CANCELLATION AND NO SHOW POLICY.

PRINT NAME SIGNATURE OF PATIENT/PT REPRESENTATIVE DATE