

Advanced Podiatric Specialists
1389 West Main Street * Suite 222
Waterbury, CT 06708
Phone (203) 757-9200 * Fax (203) 757-3990

Name _____ Social Security# _____ - _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Sex: M F Age _____ Single Married Widowed Divorced (**Circle one**)

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Email _____ Occupation _____ Employer _____

Emergency Contact Name _____ Relationship to you _____ Daytime phone (____) _____

Address _____ City _____ State _____

How did you hear about our office? _____ Primary Care Physician _____

Primary Insurance _____ Copay Amount \$ _____ Effective date _____

Identification# _____ Group# _____

Policy Holder's Name _____ Relationship to patient _____

Policy Holder's Birth date ____/____/____ Social Security# _____ - _____

Insured's Employer _____ Occupation _____ Work phone (____) _____

Secondary Insurance _____ Co pay Amount \$ _____ Effective date _____

Identification# _____ Group# _____

Policy Holder's Name _____ Relationship to patient _____

Policy Holder's Birth date ____/____/____ Social Security# _____ - _____

Insured's Employer _____ Occupation _____ Work phone (____) _____

DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

I hereby name as assignee and also instruct and direct my Insurance Company to pay by check made out and mailed to the assignee: **Dr Charles T Arena 1389 West Main Street, Waterbury, CT 06708. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

I grant the assignee a limited Power of Attorney to sign my name, deposit and negotiate any insurance payment received and apply it to my outstanding balance. These payments will not exceed my indebtedness to the above-mentioned assignee. I agree that a photocopy of this Assignment shall be considered as effective as the original. In order that the assignee may submit a claim for payment for services covered under my insurance carrier and vice versa. FOR MEDICARE: I authorize any holder of medical information about me to release, to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to you any information regarding my Medicare claims under Title XVIII of the Social Security Act.

X

Date

Signature of policyholder

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize the Doctor(s), and staff of the practice as named on the reverse side of this form, to treat the patient named on this form and agrees to pay all fees and charges for such treatment. I agree to pay all charges for myself and members of my family per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree that the prevailing party will be entitled to reasonable attorney's fees and costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any lawsuits, liens or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. I understand that not all services and fees are covered by insurance. I understand that I am responsible for paying all deductibles, co- payments, non-covered services, and any portion of covered services not paid in full by my insurance. Such payments are due at the time of service or immediately upon presentation of the bill. I agree that I shall remain financially responsible for the above named patient until I notify you in writing to the contrary. This guarantee is continuing even if the actual patient, if a minor, reaches the age of majority. I authorize you or your agent to make credit investigation including employment verification. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my (the patient's) health or the above information. This instrument contains the entire and only agreement between the parties and there are no other promises, representations, or warranties, either expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument, in writing, signed by the parties hereto. You are entitled to a copy of this agreement at the time you sign, Keep it to protect your legal rights. **NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM.** I hereby acknowledge the receipt of a copy of these terms and charges and agree to them as stated and referred to herein.

X

Date

Signature by Patient (Parent must sign if patient is under 18 years)

Record ID #

Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct #

Staff Entry

Form section 1 containing patient identification fields: First Name, MI, Last Name, Your type of Job Activity / Occupation, Soc. Sec. No., Sex, Age, Birth Date, Shoe Size, Weight, Height, Phone Numbers, In Case of Emergency, Please Call, and Please Provide Your Preferred Pharmacy.

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Form section 2.1: Have you had/been treated for? List of conditions including Warts, Athlete's Foot, Corns/Calluses, Fungal Nails, Ingrown nails, Leg or Foot Ulcers, Neuroma, Foot Numbness, Broken foot bone(s), Broken Ankle, Ankle sprain, Hammer/Mallet toes, Bunions, Flat feet, Cramps in legs/feet, Arch pain, High arch feet, Lower back pain, Knee pain, Heel pain, Gait (Walking) problems, In-toeing, Toe walking, Childhood foot problems, Rash, and NONE of these.

Form section 2.2: Did you previously or do you now wear? Shoe inserts? Orthotics? Still using them? Do or did they help?

Form section 2.3: The orthotics were obtained from: Another Podiatrist, An Orthopedist, A Physical Therapist, A Chiropractor, or Other.

Form section 2.4: Are your first steps out of bed painful? Do you get leg cramps during the Day or at Night?

Form section 2.5: Percent of waking hours spent on your feet? 20%, 40%, 60%, 80%, 100%

Form section 2.6: List the sports/type of dance you are active in:

Form section 2.7: Does foot pain limit your desired activities? Do you have any difficulty in walking? Any pain in calves or buttocks when walking? Is the pain relieved by stopping & standing still?

Form section 2.8: Do you have or have you ever been treated for? List of conditions including Stroke, Heart Attack, High Blood Pressure, Phlebitis, Vascular Disease, A Heart Condition, Diabetes, Poor Circulation, Keloid/Thick Scar, Hepatitis, Liver Disease, Eyes: Glaucoma/Macular Deg., Gout, Osteoporosis, Alzheimer's, Sciatica, Lyme's Disease, Rheumatic Fever, Arthritis, Headaches, Hearing/Ear Disorder, Epilepsy, Nerve Disorder, Psychiatric Disorder, Anemia, Kidney Disease, Thyroid Problem, Asthma, Lung Disease, Tuberculosis, Cancer, Stomach Ulcer, and NONE of these.

Form section 2.9: Do you have vascular grafts? (If yes, explain below)

Form section 2.10: Do you have joint implants? (If yes, explain below)

Form section 2.11: Do you have replacement heart valves?

Form section 2.12: Are you now under active chemotherapy?

Form section 2.13: Have you had any other serious illness? (List below)

Form section 2.14: Have you had any surgery? (If yes, explain below)

Form section 2.15: Have you ever been hospitalized or been under medical care over 24 hrs? (If yes, explain below)

Form section 2.16: Had Surgery for: on date of: w/ complications of:

Form section 2.17: List relationship to you of family members who have had: Diabetes, Foot Problems, Arthritis, Heart Attack, Stroke, High Blood Pressure, Cancer, Birth Defects.

Form section 2.18: # of childbirths. Are you currently pregnant? Yes/No

Form section 2.19: Are you slow to heal after cuts? Yes/No

Form section 2.20: Any abnormal bruising, bleeding or scarring? Yes/No

Form section 2.21: Do you smoke now? No/Yes Packs/day Years

Form section 2.22: Did you ever smoke? No/Yes Packs/day Years

Form section 2.23: If you quit, when did you do so?

Form section 2.24: Alcoholic beverages? (Circle one) None Rarely Moderately Daily Quit

Form section 2.25: Recreational Drugs? (Circle one) None Rarely Moderately Daily Quit

Form section 2.26: Please mark if you take vitamins or supplements that contain garlic, Gingko biloba, echinacea, ginseng or St. John's Wort

Form section 2.27: Are you currently taking any medications? List below! Yes/No

Form section 2.28: Are you taking insulin? If yes, list below. Yes/No

Form section 2.29: When noting frequency: A = As needed, x/ = times per D = day, W = week, List: Medications Dose? How Often? For Treatment of?

Table for listing medications with columns for Medication, Dose, Frequency, and Treatment.

Form section 2.30: Are you taking your medications as prescribed? Yes/No

Form section 2.31: Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Form section 2.32: (Check the answer box that applies) No Yes If yes, what happens?

Table for listing allergies with columns for Allergy Name, No, Yes, and If yes, what happens?

Form section 2.33: Others:

Form section 2.34: Anything else that you want to tell the doctor? Yes/No

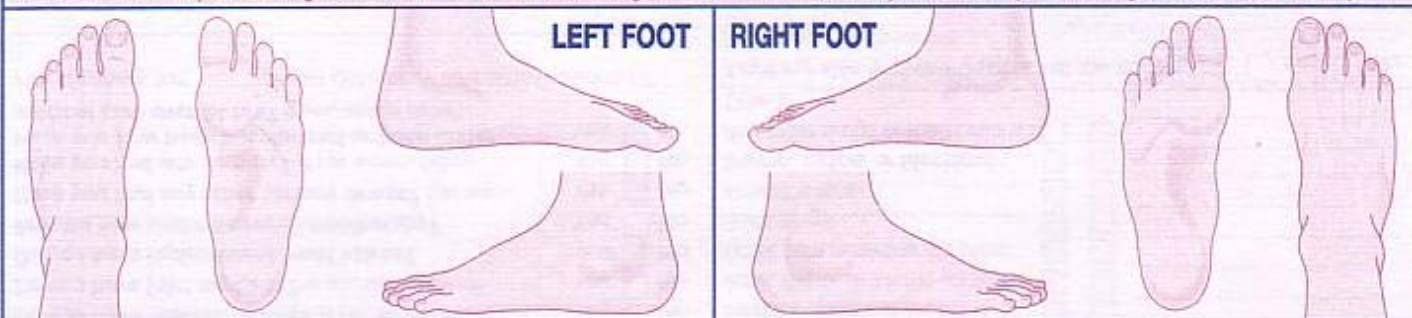
Form section 2.35: Illnesses/Explanations:

INITIAL HISTORY

UPDATE OF HISTORY TAKEN

PATIENT HISTORY AS OF / /

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



1 Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡
 My first problem is ... On Left foot On Right foot On Both feet.
 It causes me difficulty: walking, wearing shoes, and/or it ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
 Shooting Pain
 Throbbing Pain
 Sharp Pain
 Burning Pain
 Itching
 Aching Pain
 Tenderness
 Dull Pain
 Tingling
 Numbness

How long ago did the problem (pain) start?:
 _____ days, _____ weeks, _____ months, _____ years ago

The pain from my problem occurs:
 while walking and/or while not walking
 and/or: _____

Previous medical treatment(s) or home remedies:

2 Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡
 My second problem is ... On Left foot On Right foot On Both feet.
 It causes me difficulty: walking, wearing shoes, and/or it ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
 Shooting Pain
 Throbbing Pain
 Sharp Pain
 Burning Pain
 Itching
 Aching Pain
 Tenderness
 Dull Pain
 Tingling
 Numbness

How long ago did the problem (pain) start?:
 _____ days, _____ weeks, _____ months, _____ years ago

The pain from my problem occurs:
 while walking and/or while not walking
 and/or: _____

Previous medical treatment(s) or home remedies:

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/Primary	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcl Eval <input type="checkbox"/> Consult
Specialist	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcl Eval <input type="checkbox"/> Consult
Other Podiatrist	_____	_____	_____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Surgcl Eval <input type="checkbox"/> Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

- Patient was assisted in completion of this record by or was unable to complete without the help of: _____
- Translation was done by _____ in Spanish, _____
- Additional Information† obtained from Family/Care givers and/or Physician(s) _____
- Lab Reports† and/or Previous Medical Records† were reviewed. X-rays† brought by patient from _____ were reviewed.

† Elaborations: _____

I have reviewed the information provided above _____ My annotations to patient's entries are marked in: _____ (INK COLOR)

Doctor's Signature **X** _____ Date / / See Additional Documentation

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Patient Medication List

Please carry this with you at all times and update it as often as possible

Patient Name: _____

Date Updated: _____

Medication	Dosage (mg)	Times per day

Please list any allergies to medications below

Medication name	Reaction or symptom experienced

WHY DO I HAVE TO FILL OUT ONE OF THESE MEDICATION LISTS AGAIN?!

Research has proven that the most common causes of illness in the elderly and of failed cures in people of any age, are incorrect medication combinations. It is very easy to take the wrong pills or the wrong dosage.

At most medical appointments, some changes are made in medications. If the doctor doesn't know precisely what you are on at the beginning of the appointment then there may well be a mistake made by the end of the appointment.

Another common mistake occurs when a patient has one bottle of pills with a generic name and they end up taking a double dose causing severe overdoses and possible severe medical problems. This problem occurs frequently in patients on diuretics, heart medications, antibiotics or arthritis pills.

In addition, mistakes can be made in the doctor's memory, the patient's memory, the typist transfer of thoughts to paper or at the pharmacy. For all of these reasons current and constantly updated medications lists are one of the best ways to assure that medication errors will not be made.