

WELCOME TO NORTHEAST IOWA PODIATRY, P.C.

First Name: _____ MI: _____ Last Name: _____

Gender: Male ___ Female ___ SSN: ____-____-____ Birthdate: ____/____/____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Best Time To Reach You? _____

Marital Status: S M W D Are you a student?: yes no Are you employed?: yes no

Place of Employment: _____

Race White Black / African American American Indian / Alaska Native Asian
 Native Hawaiian / Other Pacific Islander Not Specified

Ethnicity Not Hispanic / Latino Hispanic / Latino

Emergency Contact (Name and Phone): _____

Primary Care Physician: _____ **Date Last Seen:** ____/____/____

Referring Doctor: _____

Primary Insurance:

Secondary Insurance:

Required if different than patient

Required if different than patient

Insured Name: _____

Insured Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Date of Birth: ____/____/____

Date of Birth: ____/____/____

Policy Number: _____

Policy Number: _____

Group Number: _____

Group Number: _____

Patients Name : _____

MEDICAL AND PODIATRIC HISTORY

My foot problem is: _____

Is this due to an injury? _____ If yes, is it work related? _____ Date of Injury _____

Right Foot Left Foot Both Feet

It has troubled me for: _____ weeks _____ months _____ years

Are you allergic to any of the following?:

_____ Adhesive/Tape _____ Aspirin _____ Codeine

_____ Demerol _____ Iodine _____ Novocain

_____ Penicillin _____ Seafood _____ Sulfa

Others: _____

Do you have a family history of any of the following?:

_____ Arthritis _____ Diabetes _____ Foot Problems Other: _____

List current medications being taken: _____

Have you ever been treated for any of the following?:

_____ AIDS/HIV _____ Epilepsy _____ Psychiatric Problems

_____ Anemia _____ Glaucoma _____ Rheumatic Fever

_____ Artificial Heart Valves _____ Gout _____ Stomach Problems

_____ Asthma _____ Heart Problems _____ Stroke

_____ Back Problems _____ High Blood Pressure _____ Other: _____

_____ Bleeding Tendencies _____ Kidney/Bladder Problems _____

_____ Cancer _____ Liver Problems _____

_____ Diabetes _____ Neuromuscular Diseases _____

List surgical operations: _____

Are You a smoker?: yes no

Your Pharmacy Name: _____ **Location:** _____

ASSIGNMENT AND RELEASE

- I hereby give Dr. Stephen Solomon, Dr. Kelsey Harvey and associates permission to diagnose and treat my foot condition.
- I also authorize this office to release medical information to insurance carriers necessary in securing payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for giving "Northeast Iowa Podiatry, PC" the correct insurance information at the time services are rendered. Northeast Iowa Podiatry, PC agrees to bill your insurance carrier(s). All insurance information must be provided to our office, at the time of service.
- I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.
- I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion). I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties.
- I understand that Northeast Iowa Podiatry, PC is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

Signature of Responsible Party

Date

Name of Responsible Party (If different from the patient) _____

Address (If different from patient) _____

Acknowledgement of Receipt of Notice of Privacy Practices

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 understand the Notice.

Patient Name (please print)

Date

Parent of Authorized Representative (if applicable)

Signature

Medicare Part B Signature Authorization

Patient Name (please print)

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION.

Signature