

Christopher B. Stewart, DPM
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Phone (434)979-0456

NEW PATIENT INFORMATION



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Phone (804)658-1883

PLEASE PROVIDE ALL YOUR INSURANCE CARDS TO THE RECEPTIONIST TO BE COPIED

Patient Name _____
First Middle Last Name you wish to be called

Address _____ Responsible Party _____
Street City State Zip If Minor

Home Phone (____) ____ - ____ Cell Phone(____) ____ - ____ Email _____

Date of Birth ____/____/____ Age ____ Sex (circle): Female/Male

Marital Status (circle): Single Married Widowed Separated Divorced

SSN# _____ Emergency Contact _____ Phone (____) ____ - ____

Primary Care Physician _____ Date of last Visit _____

How were you referred to our office? Doctor Internet Website Insurance Patient Phonebook Newspaper

Preferred Pharmacy (Name and Location) _____

Employer _____ Work Phone (____) ____ - ____ Position/Occupation _____

Race (circle): American Indian or Alaskan Native Asia Black or African American
Native Hawaiian or Pacific Islander White or Caucasian Hispanic or Latino

Primary Language _____ Secondary Language _____ Height __ft. __in. Weight _____ lbs.

What is the chief complaint for which you came to be treated for? _____

Circle all that apply: Left Foot Right Foot Left Ankle Right Ankle Toes Nails

How long have you had your symptoms? _____ Is it associated with an injury? YES NO

What makes it better? _____ What makes it Worse? _____

Problem Status (circle): Problem getting worse Problem staying the same Problems improving

INSURANCE AUTHORIZATION

Name of Insurance Subscriber (if different than patient. Exp. spouse, parent or guardian that the insurance)

_____ Relationship to patient _____
First Last

Date of Birth (of insured) ___/___/___ SSN# _____ Phone(____) ___ - _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT AND RELEASE

I hereby give Christopher B. Stewart, DPM, PC & Maryellen A. Waltz, DPM, PC, The Podiatry Group, and its staff member's permission to treat my feet and/or ankle disorders. I the undersigned, have insurance coverage with _____ and assign directly to Christopher B. Stewart, DPM, PC all medical 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. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

X _____
Signature of Insured/Guardian

___/___/___
Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Christopher B. Stewart, DPM, PC, The Podiatry Group, for any services furnished me by the physician. I understand my signature request that payment be made and authorizes release of medical information, necessary to apply the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X _____
Beneficiary Signature/Guardian

___/___/___
Date

Please include any notes regarding a care takers and/or care facility that may be relevant to contacting the patient and/or patient care.

MEDICAL HISTORY Continued

We welcome you to the practice. Completion of this questionnaire regarding your medical history and present condition will assist us in the diagnosis and treatment of your feet and/or ankle condition. All information will be part of your confidential medical record.

REVIEW OF SYMPTOMS (Please check chronic symptoms you have had in the past year)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Ankle Pain/Swelling | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Earache | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Numbness (Legs/Feet) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Bloating/Gas | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Shoulder & Neck Pain |
| <input type="checkbox"/> Bloody Urine | <input type="checkbox"/> Headache | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sleep Loss |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Urinate frequently |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Itching, Keloids (Scar Tissue) | <input type="checkbox"/> Weight Loss |

MEDICAL HISTORY (Please check conditions you have or have had in the past)

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Blood Clot(s) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> PVD (Peripheral Vascular Disease) |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |
| | <input type="checkbox"/> Mental Illness (Type _____) | <input type="checkbox"/> Other _____ |

FAMILY MEDICAL HISTORY (To the best of your knowledge, please specify family member(s) –Mother, Father, Sister, Brother, Maternal Grandmother or Grandfather and Paternal Grandmother or Grandfather)

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Congenital Anomaly | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Births |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Stroke |
| | | <input type="checkbox"/> Substance Abuse |

MEDICAL HISTORY

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SURGICAL HISTORY (List and surgeries you have had and approximate year)

Surgery Name and/or Description

Year

Surgery Name and/or Description

Year

Surgery Name and/or Description

Year

Surgery Name and/or Description

Year

Surgery Name and/or Description

Year

MEDICATIONS (List all medications you are currently taking and dosage if known)

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Rx _____

Circle all that Apply: Gold Therapy Chemotherapy Accutane Corticosteroids (Ex: Prednisone)

ALLERGIES (List all Allergies)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Iodine	_____
<input type="checkbox"/> Novocain	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Tape/Adhesive	<input type="checkbox"/> Latex	_____	_____
<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Sulfa Drugs	_____	_____

SOCIAL HISTORY (Circle what applies)

<u>Tobacco/Nicotine</u>	Never	Formerly	Rarely	Occasional	Everyday		
<u>Alcohol</u>	Never	None	Rarely	Occasional	Social	Moderate	Heavy
<u>Caffeine per Day</u>	0	1	2	3	4+		

Welcome to Our Office

FINANCIAL POLICIES

Thank you for choosing us as your Podiatric Physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

INSURANCE: If your Doctor is a participating provider with your insurance plan, we will submit your claims to your insurance company for any podiatry issues you are being treated for. To do this we must have complete and accurate insurance information and a copy of your identification card. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. If you have an annual **deductible** which has not yet been paid in full then any charges incurred up to that amount are **due at the time of your visit.**

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENTS: Payments for the balance due, co-payments, deductible, non-covered supplies, etc., are due at the time of service and may be made by cash, check or credit card (**Visa, MasterCard, Discover, AMX and Debit**). There will be a \$35.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

REFERRALS: Some insurance companies require subscribers to have a referral from a primary care physician prior to being seen by a specialist. It is your responsibility to contact your PCP if a referral is needed, no services will be rendered until the referral has been received or the patient pays for the services at the time they are rendered.

NON-PAYMENT/PAST DUE ACCOUNTS: Please be aware that if a balance remains unpaid for 60 days, we may refer your account to a collection agency, and your account will be charged an additional \$50 for all collections expenses and court costs. Partial payments are only accepted if negotiated in advance with the office manager.

MISSED APPOINTMENTS/NO SHOWS: In an effort to meet the demands for patient appointments, please call our office 24 hours in advance if you are unable to keep your scheduled appointment, this allow us to accommodate our other patients. It is our policy to charge a \$25.00 fee for missed appointments not canceled within 24 hours prior to the scheduled appointment. We understand that 24 hour notice is not always possible and we will take these on a case by case basis. If you must miss an appointment, please call us as soon as you know you cannot make it. Patients who habitually do not show and do not contact us take time away from other patients, and will be asked to find another provider. Our policy is to charge a fee of \$150.00 when patients cancel surgery less than 2 weeks before the scheduled surgery date.

FORM COMPLETION: We reserve the right to charge a reasonable fee of \$5.00 for form completion. i.e. Disability forms, Family medical leave forms etc.

ORTHOTICS: Orthotics is a non-covered service by most insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotics benefits. A deposit of \$100 is requested at the time of the examination and casting and full payment is due when orthotics are dispensed.

SUPPLIES: For your convenience, we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. These are non-covered items and we cannot bill insurance for these items. All retail items are final sale. No refunds will be given unless the product is defective, in this case an exchange will be made.

I, the undersigned, have read, understand and agree to the policies described above, and understand that Christopher Stewart, DPM, PC, The Podiatry Group will render services in consideration of and reliance on my authority to agree and my agreement to abide by the terms/guidelines above. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effort.

X _____
Patients Signature (or Legal Guardian)

____/____/_____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In compliance with federal privacy law and regulations, all patients must, on their initial date of registration and thereafter upon request, sign and date this Written Acknowledgement Form. If you would like a copy, we are happy to provide one at any time upon request.

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND AND I CAN REQUEST A COPY, AT ANY TIME, OF THE PRIVACY POLICIES AND FULLY AGREE TO THE TERMS OF THE POLICY.

X _____
Patient Signature/Guardian

____/____/_____
Date