

**NEW PATIENT INFORMATION**

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Phone (434)979-0456



**ENTIRE FRONT PAGE IS REQUIRED**

Patient Name \_\_\_\_\_  
First Middle Last Name you wish to be called

Billing Address \_\_\_\_\_ Responsible Party \_\_\_\_\_  
Street City State Zip If Minor

[ ] Land Line Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

[ ] Mobile Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ [ ] Voice [ ] Text

[ ] Email \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex (circle): Female/Male SSN# \_\_\_\_\_

Marital Status (circle): Single Married Widowed Separated Divorced

Emergency Contact \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

\*Primary Care Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

\*Preferred Pharmacy (Name & Location) \_\_\_\_\_  
*(PLEASE DO NOT ADD CVS AS YOUR PRIMARY PHARMACY IF POSSIBLE)*

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Position/Occupation \_\_\_\_\_

Race/Ethnicity: American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Pacific Islander White or Caucasian Hispanic or Latino

Primary Language \_\_\_\_\_ Secondary Language \_\_\_\_\_ Height \_\_\_\_ft. \_\_\_\_in. Weight \_\_\_\_ lbs.

Reason for Visit? \_\_\_\_\_ Is it associated with an injury? YES NO

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

Length of symptoms? \_\_\_\_\_ What makes it better? \_\_\_\_\_ What makes it Worse? \_\_\_\_\_

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

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**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 and his 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, for any services furnished me by the physician. I understand my signature request that payment be made and authorize the 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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## 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 Heartbeat            | <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"/> COVID-19/exposure or any other highly contagious virus | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Stroke/TIA                        |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Liver Disease                      | <input type="checkbox"/> Varicose Veins                    |
| <input type="checkbox"/> Emphysema  | <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            |

Substance Abuse

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.

**SURGICAL HISTORY** (Clearly list 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

**MEDICATIONS** (List *all* meds AND dosages – YOU MAY BRING YOUR MED LIST INSTEAD OF LISTING below)

Rx _____	Rx _____
Rx _____	Rx _____
Rx _____	Rx _____
Rx _____	Rx _____

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

**ALLERGIES** (List *all* Allergies including food)

<u>  </u> Aspirin	<u>  </u> Codeine	<u>  </u> Iodine	_____
<u>  </u> Novocain	<u>  </u> Penicillin	<u>  </u> Other _____	_____
<u>  </u> Tape/Adhesive	<u>  </u> Latex	<u>  </u> None _____	_____
<u>  </u> Local Anesthetics	<u>  </u> Sulfa Drugs	_____	_____

**SOCIAL HISTORY** (Circle what applies)

Tobacco/Nicotine:    Never    Current Smoker    Occasional Smoker    Former Smoker  
When did you stop smoking? \_\_\_\_\_  
How long did you smoke for? \_\_\_\_\_

Alcohol:    Never    None    Occasional    Social    Moderate    Heavy

Caffeine per Day:    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 will not see you until you are in good standing and we may refer your account to a collection agency, and your account will be charged an additional \$50 for all collection 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 allows us to accommodate our other patients. It is our policy to charge a \$50.00 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 \$250.00 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 \$249 is requested at the time of the examination and casting and remaining balance is due when the 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 should be as valid as the original and that any attempted modification of the above terms should be void and without effort.

X \_\_\_\_\_  
Patients Signature (or Legal Guardian)

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

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## 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