Family Foot Care Centers, P.C.
Dr. Marc Fink, D.P.M.
www.familyfootcareva.com

Name: ____ Date of Birth: _____/_____/_____

E-mail address to be contacted: ____________________________ SSN# ____________________

Address: _______________________________City: _________________ State: ____ Zip: _____

Home Phone: ________________ Work Phone: _________________ Cell: _________________

Do you prefer to be called at home or at another number? ________________________________

Age: ________ Sex: M / F Weight: ________ Height: ________ Shoe Size: _________

Are you? Circle one: SINGLE MARRIED WIDOWED SEPERATED DIVORCED

Employer: _____________________________ Occupation: _______________________________

Employer Address: ____

Primary Insurance Co.: ____________________ ID# _____________________Grp: _________

Name of Subscriber: __________________DOB: ____/_____/_____SSN#___________________

Secondary Insurance Co.: __________________ ID# _____________________Grp: _________

Name of Subscriber______________________DOB: __/_____/_____SSN#_________________

Emergency Contact Name & Number:
____

Have you ever seen a Podiatrist or Orthopedist before for a foot or ankle condition? **Yes/No** Was it in the last 65 days? **Yes /No** Have you had foot or ankle surgery in the last two years? **Yes/No** If so who, where and when? Any on the job or MVA (motor vehicle accident) injuries?**Yes/No**
____

How did you hear about our office? ____

Primary Care Physician Name & Phone Number: _______________________________________

Preferred Pharmacy Name & Phone Number: ____

Reason for visit: ______________________________ how long? _________________________
____

I hereby give my permission to Family Foot Care Centers, P.C. to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition, and authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with other treating physicians. I understand that I am responsible for any co-pays and/or deductibles that my insurance requires in order to receive treatment and care. Furthermore, I assign all payments of medical benefits provided by my insurance company for medical/surgical care to Family Foot Care Centers, P.C. / Dr. Marc Fink, D.P.M.

Signature: ____ Date: ___/___/______
Patient or the person authorized to consent for patient)

Relationship to patient: ____

MEDICAL INFORMATION

Have you ever had, or been treated for any of the following?

MAJOR DISEASES

[ ] Diabetes A1C Level ______ Drawn on__________
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Angina
[ ] Arrhythmia
[ ] Heart Murmur
[ ] Mitral Valve Prolapse
[ ] Stroke
[ ] High Cholesterol
[ ] Cancer
[ ] __________________

HEENT

[ ] Headaches
[ ] Glaucoma
[ ] Hearing Problems
[ ] __________________

ARTHRITIS

[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Gout
[ ] Lupus
[ ] __________________

VASCULAR

[ ] Anemia
[ ] Prolonged Bleeding
[ ] Pacemaker
[ ] Poor Circulation
[ ] Leg Pain when walking
[ ] Varicose Veins
[ ] Blood Clots(from Surgery or otherwise)
[ ] __________________

RESPIRATORY

[ ] Asthma
[ ] Tuberculosis
[ ] Emphysema

GASTROINTESTINAL

[ ] Ulcers
[ ] Acid Reflux (GERD)
[ ] Stomach Problems
[ ] Hiatal Hernia
[ ] GI or Rectal Bleeding
[ ] Bowel Disorders
[ ] __________________

PSYCHOLOGICAL

[ ] Anxiety
[ ] Depression
[ ] Psychiatric care
[ ] Drug Dependence
[ ] Alcohol Dependence
[ ] ___________________

MISCELLANEOUS

[ ] Epilepsy/Seizures
[ ] Thyroid Disease
[ ] Muscle Disease
[ ] Kidney Disease
[ ] Bladder Problems
[ ] Prostate Problems
[ ] HIV/AIDS
[ ] Hepatitis/ Liver Disease
[ ] Venereal Disease
[ ] ____________________

DERMATOLOGY

[ ] Rash
[ ] Skin Ulcers
[ ] Fungal Nails
[ ] Phlebitis
[ ] Corns/Callouses
[ ] _____________________

OTHER MEDICAL PROBLEMS

[ ] Problems under Anesthesia
[ ] _____________________

Family History- (Who and What) [ ] Diabetes [ ] Heart Disease [ ] High Blood Pressure [ ] Cancer Other [ ] ____

Did You Smoke? Yes / No If yes, how many years? ___ How many packs per day? ___ **Did You Quit?** Y/N
Do You Drink? Yes / No **If Yes**: Socially/Daily **Females:** Are you pregnant? Yes / No

List ALL Surgeries and Hospitalizations that you have had in your lifetime?
____
____

List any and all Medications(with dosages)/Vitamins/Supplements you are currently taking:
____
____

Are you allergic to any of the following?
[ ] Latex [ ] Lidocaine [ ] Iodine [ ] Penicillin [ ] Codeine [ ] Aspirin [ ] Adhesive Tape
[ ] Tetanus [ ] Sulfa Drugs [ ] Other ____________________________ [ ] No Known Allergies
Type of Allergic Reaction_________________________ Severe____ Moderate_____Mild_____

Dr. Marc J Fink, D.P.M.
Family Foot Care
801 Volvo Parkway #130
Chesapeake, Virginia 23320
757-547-3668

I have been advised of Dr. Fink's privacy polices. These policies are posted in the office and I acknowledge that I may request a copy of these policies at any time.

Please Print Name: ______________________________________

Signature: ____

Date: ______________________

LEGAL & FINANCE FEES

All patients are responsible for payment of claims after 60 days from the date of service. If this matter is referred to an attorney for collections you will be responsible for attorney's fees of 33 1/3% and other related costs of collection. Finance charges of 1.5% will be applied monthly to all accounts not paid in 60 days.

USUAL & CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of rates within the area which are not usual and customary. If your health insurance is not active the day of your visit you will be responsible for 100% of the visit costs. It is the patient's responsibility to know and understand how their health insurance will cover them. The patient is fully responsible for any out of pocket or non-covered expenses due to lack of health coverage or non-covered health expenses. When paying by check there is a $50.00 returned check fee retuned for any reason.

ADULT & MINOR PATIENTS

Adult patients are responsible for full payment at time of service. The adult accompanying a minor patient and the parents (or legal guardian of the minor) are responsible for full payment. If you are a legal guardian you must have a custody order signed by a Judge in order to have the minor patient seen.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $70.00. Surgeries that are cancelled due to patient non-compliance (i.e. not getting labs or H&P done, or no showing for pre-op) will be charged at a rate of $250.00 Please help us to serve you better by keeping your scheduled appointments. These charges are NOT covered by your insurance company and will be the patient's responsibility.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I understand and agree to this financial policy:

X_________________________________ **DATE: __________________**
Signature of Patient or Responsible Party

X_________________________________ **DATE: __________________**
Signature of Co- Responsible Party

For Office Use Only:

We attempted to obtain written acknowledgement of our privacy policies, but the acknowledgement could not be obtain due to one or more of the following reasons:
a) Individual refused to sign
b) Communication barriers prohibited obtaining acknowledgement
c) Other (Please Specify) ____