FAMILY FOOT & ANKLE CARE
801 Volvo Parkway, Ste. 130
Chesapeake, VA 23320
www.familyfootcareva.com

NAME:_____ **DATE OF BIRTH:**_____/_____/_____

ADDRESS:_____ **CITY:**_____**STATE:**_____**ZIP:**_____

EMAIL ADDRESS:_____ **SSN of Responsible Party** _____/_____/_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL:**_____

DO YOU PREFER TO BE CALLED AT HOME OR ANOTHER NUMBER ? _____

AGE:_____ **SEX: M / F** **WEIGHT:**_____ **HEIGHT:**_____ **SHOE SIZE:**_____

ARE YOU? (CIRCLE ONE): **SINGLE** **MARRIED** **WIDOWED** **SEPARATED** **DIVORCED**

EMPLOYER:_____ **OCCUPATION:**_____

EMPLOYER'S ADDRESS:_____

PRIMARY INSURANCE CO.:_____ **ID#:**_____**GRP:**_____

NAME OF SUBSCRIBER:_____**DOB:**_____/_____/_____**SSN:**_____/_____/_____

SECONDARY INSURANCE CO.:_____ **ID#:**_____**GRP:**_____

NAME OF SUBSCRIBER:_____**DOB:**_____/_____/_____**SSN:**_____/_____/____ _____

EMERGENCY CONTACT NAME:_____ **PHONE #:**_____

HAVE YOU EVER SEEN A PODIATRIST OR ORTHOPEDIST 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 2 YRS? **YES / NO IF YES, WHO, WHERE, AND WHEN?**

HAVE YOU BEEN IN AN ACCIDENT RECENTLY? **YES/ NO**

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN NAME:_____**DATE LAST SEEN**_____ **PHONE:**_____

PREFERRED PHARMACY AND STREET LOCATION:_____

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)

PRINT NAME:_____ **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 BLEED
[ ] BOWEL DISORDERS
[ ] _____

PSYCHOLOGICAL

[ ] ANXIETY
[ ] DEPRESSION
[ ] PSYCHIATRIC CARE
[ ] DRUG DEPENDENCE
[ ] ALCOHOL DEPENDENCE
[ ] _____

MISCELLANEOUS

[ ] EPILEPSY
[ ] THYROID DISEASE
[ ] MUSCLE DISEASE
[ ] KIDNEY DISEASE
[ ] BLADDER PROBLEMS
[ ] PROSTATE PROBLEMS
[ ] HIV/AIDS
[ ] HEPATITIS / LIVER DISEASE
[ ] VENEREAL DISEASE
[ ] _____

DERMATOLOGY

[ ] RASH
[ ] SKIN ULCERS
[ ] FUNGAL NAILS
[ ] PHEBITIS
[ ] CALLOUSES/CORNS

OTHER MEDICAL PROBLEMS

[ ] PROBLEMS UNDER ANESTHESIA
[ ] _____

HAVE YOU HAD THE COVID 19 VACCINE? YES____ NO_____

JOHNSON & JOHNSON _____ MODERNA_____ PFIZER_____

FAMILY HISTORY: WHAT AND WHO? (CHECK OFF ILLNESS AND CIRCLE RELATIVE)

MOTHER FATHER BROTHER SISTER GRANDFATHER GRANDMOTHER

[ ] DIABETES [ ] HEART DISEASE [ ] HIGH BLOOD PRESSURE

[ ] CANCER: _____

TYPE – EX: LUNG, PANCREATIC, PROSTATE, ETC.)

DO YOU SMOKE? YES / NO IF YES, HOW MANY YEARS?_____ HOW MANY PACKS PER DAY?_____

DID YOU QUIT? YES / NO IF YES, WHEN? _____

DO YOU DRINK? YES / NO IF YES: SOCIALLY/ DAILY

FEMALE: ARE YOU PREGNANT? YES / NO

LIST ALL THE SURGERIES AND HOSPITALIZATIONS YOU HAVE HAD:

_____

_____

LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS WITH THE DOSAGES THAT YOU ARE CURRENTLY TAKING:

_____**MGS.** _____**MGS.**

_____**MGS.** _____**MGS.**

_____**MGS.** _____**MGS.**

_____**MGS.** _____**MGS.**

(NEED MORE SPACE FOR MEDICATIONS? TURN TO THE BACK OF THE PAGE.)

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

[ ] LATEX [ ] LIDOCAINE [ ] IODINE [ ] PENICILLIN [ ] CODEINE [ ] ASPIRIN

[ ] ADHESIVE TAPE [ ] TETANUS [ ] SULFA DRUGS [ ] OTHER _____

[ ] NO KNOWN ALERGIES

TYPE OF ALLERGIC REACTION:_____ [ ] SEVERE [ ] MODERATE [ ] MILD

(EX: VOMITING, HIVES, ETC.)

MARC J. FINK, D.P.M.
801 Volvo Parkway, Ste. 130
Chesapeake, VA, 23320
757-547-3668

I have been advised of Dr. Fink's Privacy Policies. 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 AND FINANCIAL FEES

All patients are responsible for payment of claims after 60 days from the date of service. If this matter is referred to a Collection Agency or a Collections Attorney, you will be responsible for the collection agency/collections attorney fees of up to 35%.
A finance charge of 1% per month will be applied monthly to all accounts not paid within 60 days.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and our charges are based on the usual and customary rates for our area. You, the patient, 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 insurance coverage or non-covered health expenses.

There is a $50.00 returned check fee for checks returned for any reason.

ADULT AND MINOR PATIENTS

Self-pay adult patients are responsible for full payment at the 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 the legal guardian of a minor patient, you must have a custody order signed by a judge in or 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 $250.00. These charges are not covered by insurance. Help us serve you better by keeping your appointments.

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:

_____ _____

Signature of Patient or Responsible Party **Date**

_____/_____/_____

Social Security Number of Responsible Party for Patients Under 18 Years of Age

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FOR OFFICE USE ONLY:

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF OUR FINANCIAL AND PRIVACY POLICIES, BUT THIS COULD NOT BE OBTAINED DUE TO ONE OR MORE OF THE FOLLOWING REASONS:

- **A) INDIVIDUAL REFUSED TO SIGN**
- **B) COMMUNICATION BARRIERS PROHIBITED**
- **C) OTHER (PLEASE SPECIFY):**_____

PRIVACY OPTIONS

PATIENT: _____

PLEASE SELECT ONE:

[ ] I want NO ONE to receive my Personal Health Information except myself.

[ ] I request the following person(s) BE ALLOWED to access my Personal Health Information:

NAME (PLEASE PRINT)	RELATIONSHIP	MM DD YYYY
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____

[ ] I request the following person(s) NOT BE ALLOWED to access my Personal Health Information:

NAME (PLEASE PRINT)	RELATIONSHIP	MM DD YYYY
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____

_____ ____/____/_____

PATIENT'S SIGNATURE **MM DD YYYY**