NORRITON PODIATRIC ASSOCIATES, P.C.

Use your "Tab" key to advance from field to field. After completing the forms-set, please sign and date the bottom of pages 1 and 4, then fax the paperwork back to our office at (610)292-8384 or bring it with you to your appointment.

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell Phone: _____

Work Phone: _____ Email: _____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female Primary Language:_____

Status: ☐ Single ☐ Married ☐ Widowed Full Time Student: ☐ Yes ☐ No

Occupation:_____ Employer:_____

Primary Care Physician:_____ Pharmacy:_____

Referred from: ☐ Physician _____ ☐ Friend/Patient _____ ☐ Insurance Co. ☐ Other _____

In case of Emergency call: _____ Phone #:_____

INSURANCE INFORMATION

We will scan your insurance card into our computer, but please fill out name and information for the subscriber of the insurance.

PRIMARY Insurance Company:

Insurance Co. Name: _____ Policy/ID#:_____ Group#:_____

Subscriber: _____ Relationship to Patient:_____

Date of Birth:_____

OTHER Insurance/Secondary Insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ Policy/ID#:_____

Group#:_____

Subscriber: _____ Relationship to Patient:_____

Date of Birth:_____

RESPONSIBLE PARTY INFORMATION

Person Responsible for bill (if other than patient):

Name:_____ Address:_____

City: _____ State:____ Zip:_____ Phone:_____

PLEASE READ CAREFULLY BEFORE SIGNING:

I understand that I am responsible for all charges accumulated while under Dr. Lynne Casper and/or Dr. Edward Ruane's care. Full payment is due at the time of service unless other arrangements are made in advance.

Signed: _____ Date:_____

MEDICAL HISTORY

Height:_____ Weight:_____ Shoe Size: _____

Please describe your current foot problem(s) and any previous treatment for this condition:

_____

_____

_____

PODIATRIC HISTORY

Please check those that apply:

- ☐ Ankle Sprain
- ☐ Bunions
- ☐ Corns & Callouses
- ☐ Diabetic Foot Care
- ☐ Fractures
- ☐ Fungal Nails
- ☐ Gout
- ☐ Hammertoe
- ☐ Heel Pain
- ☐ Ingrown Nails
- ☐ Neuroma
- ☐ Routine Foot Care
- ☐ Trauma
- ☐ Other _____

ALLERGY HISTORY

Please check those that apply:

- ☐ No Allergies to Medications
- ☐ Aspirin or Ibuprofen
- ☐ Tape or Adhesive
- ☐ Iodine
- ☐ Novocaine or Local Anesthetic
- ☐ Other _____
- ☐ Penicillin
- ☐ Sulfa

CURRENT MEDICATIONS

Prescription & Over the Counter ☐ No Medications

If you have a list of medications, we can make a copy for your records.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

PAST MEDICAL HISTORY

Check any of the following that you have or had a problem with.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Cancer (type)
- ☐ Depression
- ☐ Diabetes (oral)*
- ☐ Diabetes (Insulin)*
- ☐ Difficulty Walking
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Valve Problem
- ☐ Heartburn/Reflux
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidneys
- ☐ Lung
- ☐ Nervousness
- ☐ Neurologic Disorder
- ☐ Numbness
- ☐ Peripheral Vascular Dis
- ☐ Psychiatric Disorder
- ☐ Stomach/Intestinal
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcer

☐ Fracture (Ankle/Metatarsal/Toe/Hip, etc.) _____

☐ No Significant Medical History

Other Medical History Details:

_____

_____

SURGICAL HISTORY

Please check those that apply and date occurred to the best of your recollection.

- ☐ Ankle Fracture
- ☐ Appendectomy
- ☐ Bunionectomy
- ☐ Cataract
- ☐ Extremity Bypass
- ☐ Gall Bladder Removal
- ☐ Heart Bypass
- ☐ Heart Valve Replacement
- ☐ Heel Surgery
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Replacement
- ☐ Mastectomy
- ☐ Nail Surgery
- ☐ Toe Surgery
- ☐ Tonsillectomy

☐ No Surgical History

Other Surgeries:

_____

_____

Did you have any problems with anesthesia, bleeding or infection?

Explain: _____

_____

FAMILY MEDICAL HISTORY

Relationship Key: Mother (**M**), Father (**F**), Sister (**Si**), Brother (**B**), Son (**So**), Daughter (**D**)

☐ Arthritis	Relationship: ____	☐ High Blood Pressure	Relationship ____
☐ Blood Clots	Relationship: ____	☐ Kidney Disease	Relationship: ____
☐ Cancer/Type	Relationship: ____	☐ Mental/Emotional Disease	Relationship: ____
☐ Diabetes	Relationship: ____	☐ Stroke	Relationship: ____
☐ Heart Trouble	Relationship: ____	☐ Other: _____	Relationship: ____

☐ No Family Medical History

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No #____ packs per day #____ of years

Previously smoked? ☐ Yes ☐ No #____ packs per day #____ of years

Do you drink alcohol, beer or wine? ☐ Yes ☐ No

☐ Light (1-2 per week) ☐ Moderate (1-2 per day) ☐ Heavy (more than 2 per day)

EMPLOYMENT/OCCUPATION

Occupation: _____ Employer:_____

☐ Sits at job ☐ Stands at job ☐ Sits & Stands at job ☐ Always on feet at job

Leisure: Do you exercise regularly? ☐ Yes ☐ No

If yes, do you….. ☐ Walk ☐ Jog ☐ Swim ☐ Bike ☐ Lift weights ☐ Hike ☐ Other_____

PATIENT AUTHORIZATION

To Use or Disclose Protected Health Information

I consent to the use of disclosure of my protected health information by Norriton Podiatric Associates, P.C., for the purpose of providing treatment to me, obtaining payment for health care bills or to conduct health care operations of Norriton Podiatric Associates, P.C.. I understand that treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the operations of Norriton Podiatric Associates, P.C.. Norriton Podiatric Associates, P.C. is to not required to agree to the restrictions that I may request. However, if Norriton Podiatric Associates, P.C. agrees to a restriction that I request, the restriction is binding on Norriton Podiatric Associates, P.C..

I have the right to revoke this consent, in writing, at any time, except to the extent that Norriton Podiatric Associates, P.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have the right to review Norriton Podiatric Associates, P.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for Norriton Podiatric Associates, P.C. has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of the operations of Norriton Podiatric Associates P.C.. The Notice of Privacy Practices also describes my rights and Norriton Podiatric Associates P.C. duties with respect to my protected health information. Norriton Podiatric Associates P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Norriton Podiatric Associates, P.C. and requesting a revised copy be sent in the mail.

RELEASE OF INFORMATION

☐ Yes ☐ No I hereby authorize release of all medical information for insurance claim purposes.

☐ Yes ☐ No I authorize Drs. Casper and Ruane to discuss my medical condition with my primary physician and other physicians as they deem necessary to provide the best possible care.

☐ Yes ☐ No I authorize Drs. Casper and Ruane to discuss my medical condition with the following family members or friends: _____

☐ Yes ☐ No I authorize Drs. Casper and Ruane to access information concerning my current medications from **Surescripts** to allow for appropriate prescribing of medications.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered at Norriton Podiatric Associates, P.C., it's agents and staff, I hereby assign to Norriton Podiatric Associates, P.C. all benefits due me under health insurance plan covering my podiatric treatment. I hereby authorize Norriton Podiatric Associates, P.C. to process and receive medical payment for such benefits. I recognize my financial obligations to pay any co-payment, insurance deductibles, and non-covered services provided as required. This assignment of benefits shall remain in effect, even if your insurance carrier changes, until resolved in writing.

_____ _____ _____

Print Name of Patient | Signature of Patient/Guarantor | Date

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