Bazzi Podiatry Patient History Form

Patient Name: **Date of Birth:**

Address: **City:** **Zip Code:**

Cell Phone #: **Home Phone #:** **SSN:**

Email Address:

The best way to confirm your appointment:

Emergency Contact name: **Relationship:** **Phone#:**

Who Referred you to us ? ☐ **Internet** ☐ **Insurance Company** ☐ **Friend/Family** ☐ **Doctor**

Primary Care Physician Name: **City:**

PCP Phone #: **Last Visit with PCP:**

Preferred Pharmacy Name & Location (Cross streets/zip code):

Age: Height: Weight: Shoe Size:

Do you wear Wide Shoes?

No

Past Medical History

Are you currently or have you been treated for any of the following conditions?

☐ Diabetes ☐ Sickle Cell Anemia/Trait ☐ High Blood Pressure ☐ Stroke ☐ Blood Cots

☐ Gout ☐ High Cholesterol ☐ Bleeding Order ☐ Seizures ☐ Neuropathy

☐ Stomach Ulcers ☐ Arthiritis ☐ HIV or Hepatitis ☐ Asthma ☐ Cancer _____

Other Medical Problems

Are or were any <u>blood relatives</u> treated for any of the following conditions?

☐ Diabetes ☐ Amputations ☐ High blood pressure ☐ Poor circulation ☐ Neuropathy

☐ Heart disease ☐ Ulceration ☐ Bleeding disorder ☐ Bunions/corns/calluses

Please list any <u>surgeries</u> you have had both foot/ankle and body.

Do you Have a <u>Heart or Vascular</u> Specialist you currently see ? If any list name.

Are you having any of the below Symptoms ?

Constitutional

- ☐ Decreased appetite
- ☐ Headache
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Faintness
- ☐ Difficulty breathing
- ☐ Weakness
- ☐ Fever
- ☐ Diziness
- ☐ Feeling the room spinning

Cardiovascular:

- ☐ Chest/arm pain
- ☐ Heart palpitations
- ☐ Heart attack
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Heart murmur
- ☐ Cramps in legs or feet when sleeping
- ☐ Mitral Valve Prolapse

Musculoskeletal:

- ☐ Joint aches/Stiffness
- ☐ Chronic lower back pain
- ☐ Chronic ankle pain
- ☐ Chronic neck pain
- ☐ Swelling of joints
- ☐ Feet pain
- ☐ Chronic hip pain
- ☐ Morning stiffness

Integument:

- ☐ Allergy to chemicals
- ☐ Cracked skin
- ☐ Scarring
- ☐ Itching/rash
- ☐ Pain in skin
- ☐ Skin Cancer
- ☐ Thick/discolered toenails

Neurological:

- ☐ Tingling
- ☐ Pins and Needles
- ☐ Numbness
- ☐ Shooting burning pain
- ☐ Radiating Pain
- ☐ Decreased sensation to touch
- ☐ Decreased / lack of sensation to heat or cold

Endocrine:

- ☐ Diabetes
- ☐ Post menopause
- ☐ Weight loss / gain
- ☐ Increase or decrease in urination
- ☐ Increase or decrease in thirst
- ☐ Thyroid problems
- ☐ Osteoporosis
- ☐ Increase or decrease in appetite

Hematological/Lymphatic:

- ☐ Hemophilia
- ☐ Bruise easily
- ☐ Leukemia
- ☐ Sickle cell disease or trait
- ☐ Weakness
- ☐ Anemia
- ☐ Blood transfusion reaction
- ☐ Yellow discoloration of skin

Allergies: Are you allergic to any of the following?

☐ Latex ☐ Tylenol ☐ Aspirin ☐ Iodine ☐ Pinicillin ☐ Codeine ☐ Novocaine/Lidocaine

☐ Cortisone ☐ Shellfish ☐ Sulfa ☐ Tape ☐ Motrin ☐ Keflix Other

Medications:

Please list all medications that you currently take/ provide a list. (*If not enough space, list on back of this sheet)*

. Medication:_____ **Dosage:**_____**Reason for taking:**_____

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. Medication:_____ **Dosage:**_____**Reason for taking:**_____

. Medication:_____**Dosage:**_____ **Reason for taking:**_____

Social History:

Do you smoke? No **If yes, how many packs per day?** _____

Do you drink alcohol? No **If yes, how many drinks a week?** _____

Do you or have used illicit drug? No **If Yes, What kind and how often?**

Are you or could you be pregnant ? No

Insurance Information:

Primary Insurance Provider: _____

Member ID Number:_____Group #:_____

Are you the policy holder ? Yes or No

If No, list policy holder

Name:_____DOB:_____relationship_____

Secondary Insurance provider if any:_____

Memeber ID Number: _____Group#:_____

Bazzi Podiatry LLC Financial Responsibility Policy

Welcome to our office. Your understanding of our financial polices is an essential element of your care and treatment If you have any questions, please discuss them with our front office staff,

Co-Pay: The co-pay is an amount that your health plan requires you to pay any time that an office visit is billed. The payment is due on the date of service.

Annual Deductible: An annual deductible is an amount that your health plan requires you to pay toward your health care costs each year. If you have not met that deductible at the time of service at our office, you will be responsible for payment on that date of service. We will be able to assist you in determining the amount your deductible has been paid to date.

Balances: If you have paid your deductible. we will bill your insurance, you are responsible for payment to our office for your services. We will charge your onfile credit/debit card If 3 statements are sent and the full balance outstanding balance remains unpaid.
Patients without Insurance: If you do not have insurance, you are responsible for payment on the date of your service.

When Referrals Are Required: Some plans require that your primary physician write a referral to a podiatrist, which indicates conditions are to be evaluated and treated. If you are unsure if a referral is necessary, please check with our office. If a referral is required, it may be faxed or malled, prior to your visit, or you may bring it with you on the date of your visit A referral cannot be applied to the services after they have been provided.

Past Due: Past due accounts are subject to collection proceedings If statements go unpaid.

Returned Checks: There is a service fee of $25 for all returned checks.

Payment: We accept cash, American Express. Discover, MasterCard. Visa, and checks. We realize life presents us with unforeseen circumstances. We will work with you and set up a payment plan when necessary.

****Signature of patient: _____**Date:_____**

****Signature of Parent/Guardian (If Patient Is a Minor): _____**

Bazzi Podiatry LLC Authorization to Bill your Insurance

I give my Bazzi Podiatry LLC to treat my foot condition. I authorize any and all medical insurances to send payment for services directly to Bazzi Podiatry PLLC. I acknowledge that I am responsible for knowing my insurance plan and all inclusions or exclusions in coverage. As such, I understand that I may be responsible for out of pocket expenses that must be paid in a timely manner.
Failure to do so may result in cessation of services and my account being turned over to a collection agency. The undersigned patient or legally authorized representative (Agent) of the patient acknowledges that he/she personally received or was offered a copy of the Bazzi Podiatry LLC Privacy policies on the ate indicated below.

****Signature of patient: _____**Date:_____**

****Signature of Parent/Guardian (If Patient Is a Minor): _____**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV, sexually transmitted diseases, psychiatric disorders, or drug/alcohol use.
I give my consent for Bazzi Podiatry PC to release medical and other relevant information to our insurance carrier as required by my/ our insurance carrier to process medical billings.

****Signature of patient: _____**Date:_____**

****Signature of Parent/Guardian (If Patient Is a Minor): _____**