optimum FOOT CARE

Welcome

"Healthier Feet the Optimum Way"

PLEASE PRINT

HOW DID YOU HEAR ABOUT US?

☐ Doctor Referral ☐ Former Patient ☐ Insurance ☐ Friend/Family ☐ Internet/Google

Referred by: _____ Other: _____

PATIENT INFORMATION

Last Name _____

First Name_____ MI_____

Address_____

City_____ Zip _____ Age _____

E-mail_____

Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female

Social Security # _____-_____-_____

Cell Phone (_____) _____

Home / Work Phone (_____) _____

May we leave appointment or return call messages? ☐Yes ☐No

Best time to contact you: ☐Mornings ☐Afternoons ☐Evenings

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation_____ ☐ Retired ☐ Disabled

Emergency Contact_____

Phone (_____) _____ Relationship_____

CONTACTS

Who is on the patient's treatment team?

Primary Care/Medical_____

Phone (_____)_____ Last seen?_____

Endocrinologist/Diabetes_____

Phone (_____)_____ Last seen?_____

Vascular/Heart_____

Phone (_____)_____ Last seen?_____

Other Provider_____

Phone (_____)_____ Last seen?_____

INSURANCE

Policy Holder *(if NOT the patient)*_____

Relationship: ☐ Spouse ☐ Parent ☐ Other_____

Primary Insurance Co_____

Policy #_____ Group #_____

Claims address_____

City_____State_____ Zip _____

Is the patient covered by additional insurance? ☐ Yes ☐ No

RELEASE OF PERSONAL INFORMATION TO DESIGNEES

I authorize medial staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in the care and with those listed below.

NAME	PHONE	RELATIONSHIP
_____	(_____) _____	_____
_____	(_____) _____	_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize all of my insurance companies, including

_____,

*to pay and hereby assign directly to **Optimum Foot Care, LLC** and **Dr. Yacara Tabb** all benefits. **I understand that I am financially responsible for the payment of all charges whether or not paid by insurance.** I further acknowledge that any insurance benefits, when received will be credited to my account in accordance with the above said assignment.*

MEDICARE / MEDIGAP / MEDICAID AUTHORIZATION - *I request that payment of authorized Medicare benefits and, if applicable, Medigap, or Medicaid benefits, be made either to me or on behalf of **Optimum Foot Care, LLC** and **Dr. Yacara Tabb** for any services furnished to the patient by the provider. To the extent permitted by law, I authorize any holder of medical or other information about me or the patient to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine eligibility for these benefits or benefits for related services.*

Agreed & Authorized _____ Date _____/_____/_____

PODIATRIC HISTORY

What is the chief foot complaint?
(e.g. heel pain, itchy rash, painful toenails, etc.)

_____

_____

Ever been treated by a podiatrist?
(If yes, who did you see?)

_____

Ever experienced anesthesia problems?

☐ Yes ☐ No

Diabetes? ☐ Patient ☐ Family

High Blood Pressure? ☐ Patient ☐ Family

Alcohol Use? ☐ Occasional ☐ Daily

Tobacco Use? ☐ Yes, packs /day_____

☐ Yes, years used_____

Substance Abuse? ☐ Yes_____

Activities? ☐ Prolonged Standing/Walking/Climbing

☐ Sports_____

☐ Exercise regularly

Check all past or present foot problems?

Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Bunions	☐Yes	☐No
Burning or Numbness	☐Yes	☐No
Corns or Calluses	☐Yes	☐No
Flat Feet	☐Yes	☐No
Heel Pain	☐Yes	☐No
Ingrown Toenails	☐Yes	☐No
Plantar Warts	☐Yes	☐No
Swelling in Ankles or Feet	☐Yes	☐No
Shoe fitting problems	☐Yes	☐No

"Healthier Feet the Optimum Way"

PLEASE PRINT

Financial Policy

optimum FOOT CARE

It is our most sincere desire to provide you with the best possible medical care. This involves mutual understanding between the patients, our office staff, and the physicians. We encourage you, our patient, to discuss any questions you may have regarding our payment policy.

Our office requires payment at the time services are rendered. Accepted methods of payment include **Cash**, **Check**, **Visa**, **MasterCard**, and **Discover**. A $30.00 fee will be charged for all returned checks. With prior agreement, payment plans may be available for some procedures.

Patients are expected to pay for all co-payments, deductible amounts, or non-allowed, non-covered services at the time the service is rendered. Unless we have a contract directly with your insurance company, you are responsible for any difference between our charges and what your insurance company allows.

If you have insurance coverage and have provided our office with all of the necessary information and a copy of your insurance cards, our office will file a claim on your behalf. The filing of insurance claims is a courtesy, and our office cannot be responsible for negotiating insurance claims for you. We do not guarantee insurance coverage or reimbursement. The maximum time we allow for reimbursement by an insurance company is **45 days**. After that time, you will be responsible for any unpaid balance. If you have coverage through more than one insurance company, we must have that information and a copy of the insurance card.

Podiatry benefits frequently require pre-authorization, and it is your responsibility to contact your insurance company prior to your first visit. **It is your responsibility to notify this office if your insurance changes**. You are responsible for payment of services not paid by insurance up until the time we are given the new information.

MEDICAL HISTORY

Check all past or present health problems?

AIDS / HIV	☐Yes ☐No	Fainting	☐Yes ☐No	Rash	☐Yes ☐No
Anemia	☐Yes ☐No	Frequent Falls	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Artificial heart valves or joints	☐Yes ☐No	Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Back problems	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Cancer_____	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cataracts	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Ulcers	☐Yes ☐No
Chest Pain	☐Yes ☐No	Liver Disease	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Weight Loss (unexplained)	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Neuropathy	☐Yes ☐No	Other_____	
Diabetes	☐Yes ☐No	Phlebitis	☐Yes ☐No	_____	
Ear Problems	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	_____	
Epilepsy	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	_____	

Check all past surgeries?

☐Appendectomy ☐C-section ☐Carpal Tunnel Release ☐Cataract ☐Gallbladder (Cholecystectomy) ☐Hernia Repair
☐Hysterectomy ☐Joint Replacement (Hip or Knee) ☐Mastectomy ☐Pacemaker Implant ☐Prostate
☐Spinal Fusion ☐Thyroidectomy ☐Tonsillectomy ☐Weight loss (Bariatric) ☐Other_____

Is the reason for this podiatry visit due to an accident? ☐Yes ☐No If yes, please provide the incident date: _____

ALLERGIES

Check all items known to cause reactions.

☐ **NO KNOWN DRUG ALLERGIES**

☐ Adhesive Tape	☐Yes	☐No
☐ Anesthetics used during surgery	☐Yes	☐No
☐ Anticoagulant Therapy	☐Yes	☐No
☐ Aspirin	☐Yes	☐No
☐ Codeine	☐Yes	☐No
☐ Demerol	☐Yes	☐No
☐ Iodine	☐Yes	☐No
☐ Local Anesthesia (e.g. Lidocaine)	☐Yes	☐No
☐ Penicillin	☐Yes	☐No
☐ Seafood	☐Yes	☐No
☐ Sulfa	☐Yes	☐No
☐ Other: _____		

MEDICATIONS

What is the patient currently taking?
(*Include prescriptions, over-the-counter medications, and vitamins.*)

_____

_____

_____

Pharmacy Name_____ Phone (_____)_____

Pharmacy Address_____

Engaging in a treatment plan from ***Pain Management***? ☐Yes ☐No

Taking ***oral contraceptives***? ☐Yes ☐No

Currently ***pregnant***? ☐Yes ☐No

Currently trying to become pregnant? *(Fertility treatment)* ☐Yes ☐No

CONSENT TO TREAT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient