Bartlesville Podiatry – Demographic & Primary Complaint Form

It is a requirement of the federal government that this information be collected on each new patient & updated yearly for existing patients. Thank you for your cooperation, Dr. Webb & staff.

Name______________________________________ Age________ DOB____________
First Middle Last
Address______________________________ City________________ State________ Zip________
Social Sec # ______________ Sex: ☐ F ☐ M Marital Status ☐S ☐M ☐W ☐D ☐Sep
Home #______________________ Cell #____________________ Work #____________________
Email ______________________________ Patients Employer_________________________
Primary Language______________ Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Race: ☐White ☐Native America ☐Asian ☐Black/African American ☐Native Hawaiian/other Pacific Islander ☐Other

Spouse/Parent/Legal Representative Information:
Name______________________________________ Phone #____________________
Address______________________________________ Employer____________________

Emergency/Alternate Contact Name__________________________ Phone#________________
Relationship______________________________________
INSURANCE SEQUENCE - COPY OF CURRENT CARD ON FILE REQUIRED

Primary______________________________ Subscriber______________________________
Relationship ______________________ SS#______________________ DOB:____________

Secondary ______________________________ Subscriber______________________________
Relationship ______________________ SS#______________________ DOB:____________

Benefits to Physician & Release of Information:

☐**YES** ☐**NO** I hereby authorize payments directly to the physician of the surgical and/or medical benefits. I understand my insurance policy is a contract between me and my insurance company. I accept financial responsibility for payment of all deductible, co-insurance, and any other balances not paid by my insurance company. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV & AIDS. I hereby give my permission to James E Webb, Jr., D.P..M. to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature:______________________________________ **Date:**________________

What is your primary foot complaint today?______________________________________

When did this start? ___days ___weeks ___months ___years? Is the problem getting better/worse/unchanged?

Was this the result of trauma? Yes No
Does this affect your walking? Yes No
Does this affect your ability to exercise? Yes No
Does this affect your daily activity? Yes No
Was this a job related injury? Yes No If so, when did injury occur?________________

How would you describe your pain? (circle all that apply)
generalized localized throbbing radiating burning numbness dull ache sharp ache other

Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatments have you tried for this problem? ______________________________________

Do you have any other foot problems? ______________________________________

Bartlesville Podiatry – Patient History Form

Personal Information:

Patient Name____________________________________ Age______ DOB______________
Current Weight____________ Height ___________ Shoe Size __________
Primary Care Physician______________________________ Date last seen_______________
Referring Physician____________________________ Have you had a flu shot this year? □Yes □No

Past Medical History:

Are you Diabetic? **Yes No** Do you use insulin? **Yes No** Date you were diagnosed__________
What is your average blood sugar reading?__________ What was your last A1C reading? __________

Check each line	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Amputation	___	___	COPD/emphysema	___	___	Melanoma	___	___
Anaphylactic reaction	___	___	Cysts	___	___	Menopause	___	___
Anesthesia reaction	___	___	Cystic Fibrosis	___	___	Mitral valve prolapse	___	___
Anxiety disorder	___	___	Depression	___	___	Neuropathy	___	___
Arthritis	___	___	Fibromyalgia	___	___	Osteopenia/porosis	___	___
Rheumatoid Arthritis	___	___	Gout	___	___	Pacemaker	___	___
Asthma	___	___	Heart Disease	___	___	Psoriasis	___	___
Athletes Foot	___	___	Heart Valve Condition	___	___	Pulmonary embolism	___	___
Back pain	___	___	Hepatitis	___	___	Reflux/heartburn	___	___
Birth Control Pill Use	___	___	High cholesterol	___	___	Seizure disorder	___	___
Blood Clot History	___	___	HIV/AIDS	___	___	Skin ulcers	___	___
Broken Bone- Location	___	___	High blood pressure	___	___	Sleep Apnea/CPAP	___	___
Cancer	___	___	Hyper/Hypothyroidism	___	___	Stomach ulcers	___	___
Chemical addiction	___	___	Irritable bowel syndrome	___	___	Stroke	___	___
Circulation problems	___	___	Kidney disease/impaired	___	___	Tuberculosis	___	___
Clostridium Difficile Colitis	___	___	Large scars/keloids	___	___	Other______________		
Congestive Heart Failure	___	___	Liver condition	___	___	__________________		

List all medications you take and the dosage (including aspirin, birth control pills, over the counter medications and supplements, both vitamin and herbal). **IF YOU HAVE A LIST WE CAN MAKE A COPY!**

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Pharmacy ____________________________ **Location** ____________________________

Allergies (please check)

	Yes	No	If yes, list reaction		Yes	No	If yes, list reaction
Tape/Adhesives	___	___	______________	Penicillin	___	___	______________
Eggs	___	___	______________	Shellfish	___	___	______________
Iodine	___	___	______________	Sulfa drugs	___	___	______________
Latex	___	___	______________	X-ray dye	___	___	______________
Nickel/metal/jewelry	___	___	______________	Others ______________			
NSAIDS/anti-inflammatories	___	___	______________	______________			

PLEASE COMPLETE BOTH SIDES

Previous hospitalizations and surgeries: (list year and any complications)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Family History: Please check ALL that apply

Alcoholism	_____	Heart problems	_____
Amputation	_____	Kidney disease	_____
Anesthesia problems	_____	Liver problems	_____
Arthritis	_____	Lupus/autoimmune disease	_____
Bleeding disorders	_____	Malignant melanoma	_____
Bunions/foot deformity	_____	Neurologic disease	_____
Cancer	_____	Peripheral vascular disease	_____
Blood clots	_____	Pulmonary embolism	_____
Diabetes	_____	Rheumatoid Arthritis	_____
Heart disease	_____	Other __________________	

Social History (circle)

Smoking Status:	Non-smoker	Former Smoker	Current Smoker
Alcohol use:	Non-drinker	Social Drinker	Daily Use
Illicit Drug Use:	Never Used	Former User	Current User

Occupation ______________________________ **Hours per shift on your feet** ________

Review of Systems – Please circle any CURRENT symptoms you are experiencing.		
Systemic	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
Cardiovascular	Chest pain Shortness of breath	None
Motor	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
Neurological	Numbness in feet Leg pain Back pain Parathesis (nerve sensations)	None
Derm	Rash Masses Skin color changes Itching	None
Vascular	Calf/leg cramps at night Calf/leg cramps while walking Edema (swelling of legs)	None
	Cold fingers/toes Cold intolerance	None

*Please note: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

If you would like a copy of your continued care document from today, please inform the front office.

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Signature:____ **Date:**____________________
(Parent or legal guardian if minor)

Bartlesville Podiatry
1631 SE Washington Blvd.
Bartlesville, OK 74006
(918) 333-1622

WRITTEN FINANCIAL POLICY

Thank you for choosing Bartlesville Podiatry for your foot and ankle care. Our primary concern is providing quality care to all our patients. An important part of our mission is making the cost of optimal care as easy and manageable as possible for our patients by offering the following options.

Payment Options:

- Cash, Check, Visa, MasterCard, or Discover Card.
- Convenient Monthly Payment Plans offered through CareCredit.

Please Note:

Bartlesville Podiatry requires payment at the time of service for all self- pay accounts.

For patients with insurance, we are happy to file any claim to your insurance company. In the event your health plan determines services are ***"NOT COVERED"***, or you do not have authorization, you will be responsible for the complete charge. When in question, patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

All copays, down payments, and non- covered services or products are due at the time of service.

For all custom orthotics and outpatient surgeries, a **$100.00 down payment** will be required at the time of casting or scheduling. Once your insurance company has processed the claim, you will be refunded any overpayment received.

Customized devices, orthotics and/or durable medical equipment (DME) are non- refundable unless the device is found to be defective.

All account balances which include all co insurance, deductibles and other patient responsible portions, must be paid within 90days of the date of service.
Delinquent accounts will be turned over to Collection Agency. At that time a 30% fee will be added to your account to cover the collection fees and report will be made to the collection bureaus. In the event your account is turned over for collections, you will be required to pay any outstanding balance in full prior to initiating additional treatment with the practice. Delinquent accounts are subject to dismissal from this medical practice.

Returned checks will be charged **$25.00** and must be paid before additional services can be preformed.
I understand if I do not cancel my appointment within 24 hours I will be charged a $50.00 fee.

If you have any questions regarding this financial policy or your account please contact our Billing Manager at (918) 333-1622 Mon- Thurs. from 8:30 am- 4:30 pm and Fri 8:30 am – 3:00 pm.

______________________________________ ____________

Patient, Parent or Guardian Signature Date

Policy Effective Date: 08/11/2020

Bartlesville Podiatry

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

*Personal health information may be disclosed or used for treatment, payment, or healthcare operations.

*The practice reserves the right to change the privacy policy as allowed by law.

*The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

*The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

*The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**
If YES, please name the members allowed:	**YES**	**NO**

____

____

The consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ________________________________ **Date:** ________________

Witness: ________________________________ **Date:** ________________