McDOWELL PODIATRY
TREATMENT OF THE FOOT AND ANKLE

Diplomate American Board of Foot and Ankle Surgery
Fellow of the American College of Foot and Ankle Surgery
Fellow of the Association of Extremity Nerve Surgeons

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PLEASE PRINT CLEARLY ***(****except signature)*

Date _____ Referring Physician: _____ Primary Care Physician: _____

Full name: _____ D.O.B: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Work#: _____ Cell#: _____

Marital Status: ☐M ☐S ☐D ☐W SSN: Contact _____ E-mail: _____

Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Patient Portal

Race _____ Ethnicity: _____ Decline to Answer (Please check) ☐

Languages: _____ Employer: _____

Employer Address: _____

Parent/Guardian: _____ Phone#: _____

Emergency Contact: _____ Phone#: _____

***Primary Insurance**

Insurance Company: _____ Subscriber: _____ Subscriber D.O.B: _____

ID#: _____ Group#: _____

***Secondary Insurance**

Insurance Company _____ Subscriber: _____ Subscriber D.O.B: _____

ID#: _____ Group#: _____

***Authorization of Treatment**

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Print name: _____

Relationship to patient: _____ Self: _____

How were you referred to us? (check all that apply) ☐ **Primary Care** ☐ **Specialist** ☐ **Insurance** ☐ **Hospital** ☐ **Family/friend**

☐ **Public Speaking** ☐ **Health Fair** ☐ **Internet Site**_____ _ **Patient in the practice**_____
Website name *Name*

Patient Name_____

Patient Intake Form

Reason for your visit : _____

Male: _____ Female: _____ Height: _____ Wt: _____ Shoe size: _____

Pharmacy: _____ Street or Phone#: _____

Medication Allergies: _____ Reaction: _____

Medication Allergies: _____ Reaction: _____

Latex Allergies: ☐ Yes ☐ No Tape Allergies: ☐ Yes ☐ No Other Allergies: _____

Current Medications taken: (or Attach List)

_____

_____

FAMILY MEDICAL HISTORY (CHECK ALL THAT APPLY) (CHECK FAMILY MEMBER)

NO PAST FAMILY HISTORY	☐	
ANXIETY	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
HYPERTENSION	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
DIABETES / TYPE	☐ / ____	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
HEART ATTACK	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
STROKE	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
CANCER ☐ TYPE _____		☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
PERIPHERAL VASCULAR DISEASE	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER
PERIPHERAL NEUROPATHY	☐	☐ MOTHER ☐ FATHER ☐ SIBLING ☐ OTHER

SOCIAL HISTORY:

Marital Status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation: _____ Full time ☐ Part time ☐ Light duty ☐ Disabled ☐

Student: ☐ Full time ☐ Part time ☐ Retired ☐ Other _____

Do you live in a single story or multilevel home? ☐ Single ☐ Multilevel Do you live alone? ☐ Yes ☐ No

Do you have a care giver? ☐ Yes ☐ No Assisted Living? ☐ Yes ☐ No

Care giver /Assisted Living Name : _____ Phone number: _____

Do you smoke? ☐ Yes ☐ No When did you quit? _____ How long you smoked: _____

Alcohol intake: ☐ Never ☐ Occasionally ☐ Frequently

Exercise Level: ☐ Low ☐ Moderate ☐ High

Activities: _____

SURGICAL HISTORY:

Foot/Ankle surgery: _____ Date performed: _____

Patient Name _____

Other surgeries: _____ Date performed: _____

PERSONAL MEDICAL HISTORY (CHECK All THAT APPLY) OR **NO PAST MEDICAL HISTORY**(☐)

ANXIETY	☐	HIATAL HERNIA	☐
REFLUX DISEASE	☐	HEPATITIS	☐
PACEMAKER	☐	HEART ARRHYTHMIA	☐
HEART ATTACK	☐	STROKE	☐
HIV/AIDS	☐	LIVER DISEASE /TYPE	☐ / _____
HIGH CHOLESTEROL	☐	LEG/FOOT ULCER	☐
HYPERTENSION	☐	KIDNEY DISEASE	☐
GOUT	☐	FIBROMYALGIA	☐
DIVERTICULITIS	☐	ORGAN TRANSPLANT	☐
OSTEOPOROSIS	☐	LUNG DISEASE	☐
CLAUSTRAPHOBIA	☐	ASTHMA	☐
ARTHRITIS	☐	TUBERCULOSIS	☐
BLEEDING DISORDER	☐	BLOOD CLOT	☐
PERIPHERAL VASCULAR DISEASE	☐	PERIPHERAL NEUROPATHY	☐
URINARY TRACT INFECTIONS	☐	CORONARY ARTERY DISEASE	☐

CANCER ☐ TYPE _____
STATUS OF CANCER _____ HAND DOMINANCE RT ☐ LT ☐

DIABETES / TYPE ☐ / _____ OTHER _____
DIALYSIS ☐

Are you currently seeing a vascular surgeon or cardiologist ☐ Yes ☐ No

If so, who is the physician _____

History of Current Symptoms

Symptoms: ☐ Pain ☐ Burning ☐ Numbness ☐ Redness ☐ Swelling ☐ Tingling ☐ Aching ☐ Drainage

Other Symptoms: _____ Right ☐ Left ☐ Bilateral: ☐ Top: ☐ Bottom: ☐ Side of foot: ☐

Severity: Mild ☐ Moderate: ☐ Severe: ☐ Pain scale ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Onset or Date of Injury: _____ Have you had this in the past? _____

When are symptoms at their worst: Morning: ☐ Daytime: ☐ Night time: ☐ Other: _____

How did injury occur? _____ **Work Related**? ☐ Yes ☐ No **Auto Accident**? ☐ Yes ☐ No

What makes it better? _____

What makes it worse? _____

Working? ☐ No ☐ Regular duty ☐ Modified duty Additional Notes: _____

Diagnostic testing: ☐ X-ray ☐ MRI ☐ CT If so: Where _____ When: _____

List any previous treatment: _____

Is there any other information about yourself that you feel we should know? If so, please explain below:

_____

Patient Name_____

Assignment of Benefits Form

Financial Responsibility All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plane to issue payment check(s) directly to Dr. Brian A. Mc Dowell, DPM for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information I hereby authorize Dr. Brian A. Mc Dowell to (1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination or treatment (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Brian A. Mc Dowell on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PRINT NAME **Date**

_____

Patient or Responsible Party Signature **Date**

Patient Name_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the Privacy Practice Notice.

® It tells me how the practice will use my health information for the purposes of my treatment, payment for my treatment, and health care operations.

® The notice explains in more detail how the practice may use and share my health information for other than **T**reatment, **P**ayment and health care **O**perations.

® The practice will also use and share my health information as required/permitted by law.

® I authorize to disclose my medication history to the practice.

Note: Uses and disclosure for **TPO** may be permitted without prior consent in an emergency.

Disclosures of Personal Health Information

Date _____ PLEASE LIST THE NAMES OF WHOM YOU GIVE US PERMISSION TO DISCLOSE INFORMATION TO OTHER THAN PHYSICIANS. _____ _____ _____

Authorization to leave messages on Voice Mail? ☐ Yes ☐ No
Authorization to send appointment reminders through text ☐ Yes ☐ No

Patient's complete name: _____

Patient's DOB: _____ Date: _____

Signature: _____
Patient or legal representative

FINANCIAL POLICY

CANCELLED APPOINTMENTS This office requires 24 hours notice if you are unable to keep your scheduled appointment. (Initials_____)

INSURANCE Co-payments are due at the time of each visit and it is your responsibility to inform the office of the amount of your co-payment. If co-payment is not made, you will be billed. The bill will include a $10.00 (Initials_____) billing fee per statement.

In order to file claims for you it is required that you sign an assignment of benefits form for your insurance.

As a service to our patients, we can set up your account to automatically charge your chosen credit card through **Credit Card Plus** for your deductible and co-insurance amounts once your insurance company has processed the claim.
You may be required to pay co-insurance, a deductible and a co-payment as determined by the medical coverage you have chosen for surgery, orthotics and other services. These payments may be collected at the time of service.

PAYMENT TYPES For the convenience of our patients we offer a variety of payment types. We accept cash, check, and credit cards. We offer a payment plan, **CREDIT CARD PLUS,** which automatically charges your credit card each month for self-pay balances. We also make other payment arrangements as needed.

If your payment is returned by your bank for any reason you will be charged $35.00 and it will be added to your account balance. (Initials_____)

Patient Printed Name _____

Patient/Guardian Signature_____ Date_____

Printed Name of Person Signing _____