Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers
	☐ constipation	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite
	☐ **NONE**				
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin
	☐ **NONE**				
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders
	☐ **NONE**				
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis
	☐ **NONE**				
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Rev 1/21/2015

NEWTOWN
FOOT & ANKLE
SPECIALISTS
www.NEWTOWNPODIATRY.com

Dr. William Lynde
Dr. Michael Lynde
Dr. Amy Hall
Dr. Michael Rossidis
Dr. Allan Jaffe

770 Newtown-Yardley Road Suite 215 • Newtown, PA 18940 • Tel: (215) 968-8700 • Fax: (215) 968-8523

RECORDS RELEASE AUTHORIZATION

TO:_____

_____

_____

I HEREBY AUTHORIZE & REQUEST YOU TO RELEASE TO NEWTOWN FOOT & ANKLE ANY MEDICAL RECORDS THAT ARE REQUESTED BY THIS OFFICE.

NAME:_____

SIGNED:_____

DATE:_____

ADDRESS:_____

_____

DATE OF BIRTH:_____

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The Department of Health & Human Services has established a Privacy Rule to help insure that personal health information is protected for privacy. The standards for the misuse of Personal Health Information (PHI) are designed to protect your information when disclosing information that is needed to carry out proper treatment, payment, or health care operations.

As one of our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When necessary, we provide the minimum amount of health care information to only those we feel is needed for your interest.

Please note that we support your full access to your Personal Health Information. If you do not want someone to have you information, just inform our office manager or your physician so it can be noted in your chart. We will ask you to authorize release of your information to any party that is directly connected to your treatment, payment, or health care options.

If you have any questions or objections to this privacy policy kindly ask to speak with our office manager or your physician. Please sign below to acknowledge that you have read this notice of privacy.

Patient's Name:_____

Signature:_____

Date:_____

If Minor, signature of parent of guardian:_____

An effort was made to get a signature but we were not successful. Date:_____

I authorize information to be released to:

_____

_____Relationship to patient

I authorize that a message may be left on my answering machine for any information at the following #_____ Initials_____

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Patient Financial Responsibility Agreement

The doctors and staff of Newtown Foot & Ankle Specialists appreciate the confidence you have shown in choosing us to provide for your medical needs. We are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian) is responsible for the payment for his/her treatment and care and co-pay is required at the time of visit.
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Co-pays are due at the time of service. We accept cash, checks, money orders, Visa, MasterCard, American Express and Discover.
- Patients may incur, and become responsible for the payment of the following additional charges:
  - A $30 fee for all returned checks
  - While we understand there may be times when you miss an appointment due to emergencies or illness, NFAS requires a 24 hour notice on cancelled appointments. A $50 fee may be applied towards no-show office visits
  - An administrative fee of $25 for completing forms such as DMV, FMLA and disability. Forms require 5 to 7 working days and notification or presentation of the form by the patient to the NFAS staff

Insurance

The following are the patient's responsibility:

- Patient's must bring their insurance card to each visit*
- Notify our office of any changes to insurance/address/phone numbers
- Obtain a referral (if required by insurance) from their primary doctor prior to their appointment time
- Know their copays, benefits and coverage (e.g., referrals, prior-authorizations, radiographs, lab tests)
- Determine if our doctor(s) are in-network providers prior to first visit
- Pay for any allowed amounts not covered by insurance

*If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.
**Worker's Compensation and Auto Accident cases must provide claim number, name of the carrier, date of injury, employer and number of claim adjuster.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Newtown Foot and Ankle Specialists reserves the right to change or amend this statement at any time and at its discretion.

_____
Printed name of patient

_____ _____
Patient (or guardian's) signature Today's Date

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Opioid Treatment Agreement

I, _____ D.O.B.___/___/___, understand that compliance with the following guidelines are important in the event that I am prescribed an opioid medication (narcotic) for treatment of pain at Newtown Foot & Ankle Specialists.

1. I understand that I have the following responsibilities if prescribed a pain medication:
   a. I will inform my doctor if I have or have had a substance abuse problem
   b. I will only take the dose and frequency as prescribed
   c. I will not request opioids, or any other pain medications, from other doctors
   d. I will inform this doctor of all other medications that I am taking
   e. I will protect my prescriptions and not share them. I realize that lost or stolen medication will not be replaced. I promise to keep all of my medications away from children.

2. I understand that opioids are highly addictive and if I believe I have a substance control problem I will seek help.

3. I am aware of potential side effects of opioids such as decreased reaction time, clouded judgment and drowsiness. I realize the potential danger associated with the use of opioids especially when driving or operating heavy equipment.

4. I understand that if my pain exceeds a three-week treatment period of narcotic medications Newtown Foot & Ankle Specialists may refer me to a Pain Management Center.

I have read this document, understand and have had all of my questions answered satisfactorily. If prescribed, I consent to the use of opioids to help control pain.

_____ _____

Patient's signature Today's Date

_____ _____

Guardian's signature Today's Date