FOOTPRINT PODIATRY CONSULTANTS, LLC

1328 Southern Avenue SE - Suite 209 - Washington, DC 20032
Office (202) 506 - 1001 **Fax** (202) 506 - 1008

New Patient Encounter Form

Today's Date: _____

Patient's Name: _____ Gender: M F

Date of Birth: _____ Age: _____ SS #: _____-_____-_____

Patient's Address:_____

_____

City: _____ State: _____ Zip Code: _____

Tel. #: Home _____ Cell: _____

Work #:
_____

Reason for Appointment: _____

_____
_____

Primary Care Physician's Name and Address: _____

_____

City: _____ State: _____ Zip Code: _____

Tel. #: _____ Fax #: _____

Insurance: (Please fill in all fields. If it doesn't apply, write N/A.)

Insurance Carrier:
_____

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Policy Number: _____ Expiration Date: _____

Name of Insured (If patient is covered under another person's policy, please list their name and relationship to patient here):

_____

Emergency Contact:

Name: _____

Address:_____

_____

City: _____ State: _____ Zip Code: _____

Tel. #: _____ Alternate #: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____

_____

City: _____ State: _____ Zip Code: _____

Supervisor's Name: _____ Title: _____

Supervisor's Tel. #: _____ Alternate #: _____

How did you hear about us?

_____

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Past Medical History

Please check the box below next to any and all medical problems you have been diagnosed with:

Asthma		**Gall stones**	
Atherosclerosis		**Kidney Stones**	
Abdominal Aortic Aneurysm		**Heart Attack**	
Aneurysm		**Peripheral Vascular Disease**	
Angina		**Fibromyalgia**	
Anorexia		**Lupus**	
Belimia		**Scleroderma**	
Congestive Heart Failure		**Depression**	
Cardiomyopathy		**Anxiety Disorder**	
Cancer		**Alzheimer's Disease**	
Diphtheria		**Parkinson's Disease**	
Esophagitis		**Tuberculosis**	
Gall bladder problems		**Meningitis**	
Gastric/ Acid Reflux (Heartburn)		**Urinary Bladder problems**	
Heart Murmur		**Benign Prostatic Hypertrophy (Prostate Problems)**	
Irritable Bowel Syndrome		**Uterine Fibroids**	
Crohn's Disease		**Gangrene**	
Diabetes		**Frostbite**	
Hypertension (High Blood Pressure)		**Cushing's Syndrome**	
HIV/ AIDS		**Thyroid Disease**	
Kidney Disease		**Skin Cancer**	
Liver Disease		**Anemia/ Bleeding Disorder**	
Hepatitis		**Sickle Cell Disease/ Trait**	
Glaucoma		**COPD/ Emphysema**	

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If the patient has any medical problems that are not listed, please list them here:

_____

Past Surgical History

Please list all past surgeries with date and hospital/surgery center where performed:

Type of Surgery	Date of Surgery	Place Where Surgery was Performed

Past Family History

Relationship	Living/Dead	Healthy?	Medical Problems
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling #1			
Sibling #2			
Child #1			
Child #2			

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Past Social History

Do you smoke: Y N Packs per day: _____ How many years? _____

Do you drink alcohol: Y N How many drinks per day? _____ Per week? __

Do you participate in recreational drug use? Y N What drug? _____

How often? _____

Review of Systems

Please place a check in the box next to any symptoms you have been experiencing lately:

Coughing		**Diarrhea**	
Sneezing		**Night Sweats**	
Unexplained Fatigue		**Pain in Legs/Feet/ Ankles**	
Nausea/ Vomiting		**Pain in Stomach**	
Frequent Headaches		**Coldness in Hands/ Feet**	
Blurred Vision/Double Vision		**Drainage from Ear/ Ear Infection/ Pain in Ear**	
Ringing in Ears		**Urinating Often at Night**	
Skin Rash/ Hives		**Abnormal vaginal discharge**	
Burning/ Tingling		**Foot/Ankle Redness**	
Numbness		**Blue Toes or Red Toes**	
Nose Bleeds		**Difficulty Breathing**	
Foot/ Ankle Swelling		**Difficulty Walking**	
Depression/ Anxiety		**Dark Stools/ Bloody Stools**	
Blood in Sputum		**Swollen Lymph Nodes**	
Sinus Pressure		**Back Pain**	
Hip Pain		**Knee Pain**	

Please list any other symptoms below:

_____

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Is the patient allergic to any medications, prescription or over-the counter?
Y N If yes, please list drugs the patient is allergic to and the reaction here:

_____

Initial: _____

Medications

Please list all medications in the grid below, along with their dosage and frequency (how often you take them):

Medication	Dosage	Frequency

Initial: _____

Please Note:

Patients who cancel with less than 24 hours notice and patients who miss their appointments will be charged a $30 cancellation fee. This fee must be paid by the next visit to the office before being seen by the physician. This is a non-negotiable policy. This fee is not billable to insurance companies, and is the responsibility of the patient. Payment may be by cash, credit card, or check card bearing the Visa, MasterCard, or Discover logo. Patients are not currently charged for being more than 20 minutes late, but will be seen as a walk-in, dependent upon schedule availability and doctor's availability.

Initial: _____

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Attestation

I, _____, authorize (FOR THIS AND EVERY SUBSEQUENT VISIT) the medical providers of Footprint Podiatry Consultants, LLC to diagnose and administer treatment for all of my medical problems related to the practice of Podiatry and Podiatric Surgery, thereby understanding that all medical providers will use their professional judgment in my diagnosis and treatment plans. I agree to allow Medical Assistants and/or other personnel associated with Footprint Podiatry Consultants, LLC to take vitals, pertinent history, and/or to observe performed procedures. I also agree that payment is expected and due to the provider as services are rendered, and I give Footprint Podiatry Consultants, LLC the permission to contact my insurance company for payment, giving information as applicable to assist in payment and billing. I agree that I will be charged for, and expected to pay, for any services rendered that insurance will not pay, up to the amount allowed for the visit by the insurance company. In the case of self-pay, I understand that payment must be made in full at the time services are rendered. I understand that it is my responsibility to pay my co-payment (if applicable) at the time services are rendered. I acknowledge that no guarantees have been or will be made to me regarding the outcome of my treatment. I further understand that the medical providers of Footprint Podiatry Consultants, LLC will comply with all federal, state, and local laws concerning my Protected Health Information, and will not divulge my information without my expressed written consent, except where allowed by law. I understand that this attestation begins a voluntary Physician-patient relationship with Footprint Podiatry Consultants, LLC, and Footprint Podiatry Consultants, LLC or I may terminate this relationship at any time with at least one (1) month's notice. Finally, I agree that all information I have provided herein is accurate and true to the best of my knowledge.

In the event that my insurance will not cover my services, for any reason, I agree to be designated as a self-pay patient, and will pay all fees accordingly.

I also agree to notify Footprint Podiatry Consultants, LLC of any changes in insurance coverage or employment status.

Patient Signature: _____ Date: _____

Thank you for choosing Footprint Podiatry Consultants, LLC

Footprint Podiatry Consultants
Statement on Nail Debridement vs. Nail Trimming or Clipping

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Footprint Podiatry Consultants, LLC, to include all associated physicians, **does not** perform nail trimming or clipping for any patient. Nail trimming and/or clipping are services provided by non-medically licensed personnel in nail salons and other non-medical environments.

Footprint Podiatry Consultants, LLC provides nail debridement to patients where treatment is indicated due to the diagnosis of fungus in the toenails or toenail beds. Nail debridement is a process whereby the diseased nail is shaven down and shortened in such a way that will provide comfort to the patient and help to manage and control the effect of the fungus on the toenail.

Nail debridement is provided when not only a diagnosis of fungus in the toenail is present, but also a condition of pain (in the feet, toes, toenails), difficulty walking, and/or systemic illnesses exist.

Qualifying systemic illnesses, such as a diagnosis of Diabetes Mellitus with Peripheral Neuropathy, are also considered valid diagnoses.

If conditions and requirements for nail debridement do not exist, Footprint Podiatry Consultants, LLC will not render this manner of treatment as it is considered "medically unnecessary".

Let Us Know What Your Pain Level is Today: 0-10 (0= No Pain, 10= Most Excruciating Pain): _____

Initials: _____