Section I: **Patient Information**

Name: _____ Referring provider: _____

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

Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. Are you: ☐ Employed ☐ Retired
Preferred form of contact: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-Mail

Date of Birth: / / _____ Social Security _____ Email Address: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Divorced

If Student, Name of School: _____ City/State: _____ ☐ FT ☐ PT

Spouse or Parent's Name: _____ Phone (___) _____

Whom may we thank for referring you? _____ _____

Person to contact in case of emergency _____ _____ Phone (___) _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____
Race/ Ethnici ": Asian Black Hispanic White Other Name of Primary Care Provider (Doctor

Section II **Responsible Party/ Guarantor**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (___) _____

Employer: _____ Work Phone (___) _____

Section III **Insurance Information**

Name of Insurance Carrier: _____ ID# _____ Group# _____

I authorize the release of any medical information necessary to process this claim to my insurance company, and request payment of benefits to DR. GRABOWSKI, PC.
I acknowledge that I am financially responsible for payment whether or not covered by my insurance.

PATIENT: _____ / _____
Signature Please Print Date

GUARANTOR: _____ _____ _____
Signature Please Print Date

Health History Form

Today's Date ____/ /____ Patient Name _____

GENERAL INFORMATION Height: __'____" Weight: ___ __lbs Shoe Size: (Women Only) Pregnant? ☐ Yes ☐ No

Family Physician:_____ Location:_____ Date Last Seen: / /____

Pharmacy:_____ Location:_____ Phone: (___)_____

ALLERGIES: ☐ No Known Allergies ☐ Adhesive/Tape ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Sulfa ☐ Iodine
☐ Local Anesthetics ☐ Seafood ☐ Penicillin ☐ Novocain ☐ Other:_____

CURRENT MEDICATIONS: Include prescriptions, over the counter medications, and vitamins_____ _____

SURGERIES: Please list your major surgeries _____ _____

PRIOR PATIENT & FAMILY MEDICAL HISTORY: Please indicate "Yes" if you or a family member have had any of the following:

	Patient	Family		Patient	Family		Patient	Family		Patient	Family
Aids/HIV:	☐ Yes	☐ Yes	Diabetes:	☐ Yes	☐ Yes	High Cholesterol:	☐ Yes	☐ Yes	Parkinson's:	☐ Yes	☐ Yes
Alcoholism:	☐ Yes	☐ Yes	Dialysis	☐ Yes	☐ Yes	Immunologic	☐ Yes	☐ Yes	PVD:	☐ Yes	☐ Yes
Angina:	☐ Yes	☐ Yes	Heart Attack:	☐ Yes	☐ Yes	Problems:			Seizures:	☐ Yes	☐ Yes
Asthma:	☐ Yes	☐ Yes	Heart Disease:	☐ Yes	☐ Yes	Major Trauma:	☐ Yes	☐ Yes	Stroke:	☐ Yes	☐ Yes
Cancer:	☐ Yes	☐ Yes	Hepatitis:	☐ Yes	☐ Yes	Multiple Sclerosis:	☐ Yes	☐ Yes	Thyroid Disorder:	☐ Yes	☐ Yes
Depression:	☐ Yes	☐ Yes	High Blood Pressure:	☐ Yes	☐ Yes	Obesity:	☐ Yes	☐ Yes	Tuberculosis:	☐ Yes	☐ Yes

SOCIAL HISTORY: Amount

Do you smoke? ___ Never ___ Quit ___ Light ___ Heavy ____pk/Day

Alcohol Use: ___ Never ___ Quit ___ Light ___ Heavy ___ Social

Vaccinations: Date

Flu Shot: ☐ Yes ☐ No _____

Tetanus Shot: ☐ Yes ☐ No _____

Office Use Only:

BP: /

Pulse:

DETAILED CURRENT MEDICAL HISTORY: Please indicate if you have the following. If your condition isn't listed, feel free to write it in.

Constitutional: (Physical/Mental Condition)
Addiction: ☐ Yes
Anxiety: ☐ Yes
Headache: ☐ Yes
Major Trauma: ☐ Yes
Nausea /Vomiting: ☐ Yes
No to All above: ☐ Yes

Cardiovascular: (Heart/Blood Vessels)
Anemia: ☐ Yes
Angina: ☐ Yes
Bleeding Disorder: ☐ Yes
Claudication ☐ Yes
High Blood Pressure ☐ Yes
High Cholesterol: ☐ Yes
Leg Pain When Walking: ☐ Yes
Murmur: ☐ Yes
Pacemaker: ☐ Yes
Peripheral Vascular Disease: ☐ Yes
Phlebitis: ☐ Yes
Poor Circulation: ☐ Yes
Stroke: ☐ Yes
Swelling of Foot/Ankle: ☐ Yes
No to All above: ☐ Yes

Endocrine: (Glands/Hormones)
Cold Intolerance: ☐ Yes
Diabetes: ☐ Yes
Dry Hair/Skin: ☐ Yes
Hyperglycemia: ☐ Yes
Hypoglycemia ☐ Yes
Immunologic problem: ☐ Yes
No to All above: ☐ Yes

Ears Nose Mouth, Throat:
Symptoms involving: Ear, Nose, Mouth, Throat ☐ Yes
No to All above: ☐ Yes

Eyes:
Eye problems: ☐ Yes
Glaucoma: ☐ Yes
Vision problems: ☐ Yes
No to All above: ☐ Yes

Gastrointestinal (GI): (Stomach/Intestine)
Constipation: ☐ Yes
Diarrhea: ☐ Yes
Heartburn: ☐ Yes
Negative/None: ☐ Yes

Genitourinary (GU): (Genital/Urinary System)
Kidney Dialysis: ☐ Yes
No to All above: ☐ Yes

Immunologic: (Immune system)
Allergic/ Immunologic Symptoms: ☐ Yes
AIDS/HIV: ☐ Yes
No to All above: ☐ Yes

Integumentary/Skin:
Athlete's Foot ☐ Yes
Cancer, Tumors, Cysts: ☐ Yes
Corns/Callouses: ☐ Yes
Dermatitis: ☐ Yes
Eczema: ☐ Yes
Excessive Scar Tissue: ☐ Yes
Fungus Nail/Skin: ☐ Yes
Hives: ☐ Yes
Ingrown Nails: ☐ Yes
Lower Leg Ulcer: ☐ Yes
NonHealing Wound: ☐ Yes
Plantar Warts: ☐ Yes
Psoriasis: ☐ Yes
Rash: ☐ Yes
Shingles: ☐ Yes
Skin Discoloration: ☐ Yes
Ulceration: ☐ Yes
No to All above: ☐ Yes

Hematologic/Lymphatic: (Blood/Lymph Systems)
Ankle Edema: ☐ Yes
Leg Pain: ☐ Yes
Leg Swelling: ☐ Yes
No to All above: ☐ Yes

Musculo/Skeletal:
Ankle Pain: ☐ Yes
Arthralgia ☐ Yes
Arthritis: ☐ Yes
Back/Neck pain: ☐ Yes
Bunion: ☐ Yes
Bunionette: ☐ Yes
Fibromyalgia: ☐ Yes
Flat Feet: ☐ Yes
Fractures Ankle: ☐ Yes
Fractures Foot: ☐ Yes
Fractures Toes: ☐ Yes
Gout: ☐ Yes
Heel Pain: ☐ Yes
Hip Pain: ☐ Yes
Joint Disease: ☐ Yes
Rheumatoid Arthritis: ☐ Yes
Sciatica: ☐ Yes
Scoliosis: ☐ Yes
No to All above: ☐ Yes

Nervous:
Headaches: ☐ Yes
Hearing Problems: ☐ Yes
Neurological Problems: ☐ Yes
Numbness: ☐ Yes
Seizure/Paralysis: ☐ Yes
Thyroid Problems: ☐ Yes
Tingling: ☐ Yes
No to All above: ☐ Yes

Psychiatric: (Mental State)
Addiction: ☐ Yes
Anxiety: ☐ Yes
Depression: ☐ Yes
No to All above: ☐ Yes

Respiratory:
Asthma: ☐ Yes
Bronchitis: ☐ Yes
COPD: (chronic obstructive pulmonary disease) ☐ Yes
Emphysema: ☐ Yes
Lung Disease: ☐ Yes
Sleep Apnea: ☐ Yes
Tuberculosis: ☐ Yes
No to All above: ☐ Yes

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment of my feet.

X _____ _____

Patient/ Guardian Signature Date

DR. GRABOWSKI PC.

RELEASE OF MEDICAL RECORDS

To protect your information and comply with HIPAA Standards, Dr. Grabowski PC requires all patients to provide us with a written request if you would like us to release your medical information.

I, _____ _____ hereby authorize and give my permission for the office of Dr. Grabowski PC. to disclose my private healthcare information to my insurance carrier. my medical providers, and:

None ☐

Patient Signature Date

Dr. Grabowski, PC

Cancellation and/or No-Show Policy Effective April 1st, 2012

Many doctors, especially Family Practice, stack patients (book them into overlapping time slots) to avoid having large holes in their schedules. We are very careful not to stack appointments and try to ensure that our patients get the very best care and our full attention. When our patients cancel with little or no notice or simply do not show up for their appointment, that time is wasted and there is no one to fill the hole. (If given proper notice, we are often able to fill it with someone from our lengthy wait list.)
Due to the increase of last-minute cancellations and no-shows in our appointment schedules, we have no choice but to implement the following:

Appointments that are cancelled without at least one business days notice will be billed directly to the patient as follows:

*New Patient = $50.00

*Follow up or Revisit = $25.00

****

I have read the above policy, understand and agree to pay the penalty assigned to me if I should no-show or cancel my appointment without the required notice.

_____
Patient Signature

Print Patient Name _____ Date

****Exceptions will be made for truly extenuating circumstances****

DR. GRABOWSKI PC.

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the

Notice of Privacy Practices OR had the opportunity to request one.

PATIENT: _____ / / _____

Signature Please Print Date

GUARANTOR: _____ / / _____

Signature Please Print Date

FINANCIAL POLICY FOR DR GRABOWSKI, PC

Thank you for choosing our office for your medical care. We are committed to serving you with the highest skill and quality. The podiatry care provided by Dr. Grabowski PC. are services you have elected to receive and they may imply a financial responsibility on your part.

COPAYS. Co-pays are due at the time of service.

SELF PAY. Payment in full is due at the time of service if you do not have health insurance.

MEDICARE. We are a participating Medicare provider. Medicare as well as your secondary insurance will be billed for you. You are responsible for any co-payment or deductible amounts as stated by Medicare and your secondary insurance company

SECONDARY INSURANCE. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. As a courtesy, we will bill your secondary insurance once. However, if your secondary insurance is unpaid the bill will be transferred to patient responsibility.

REFERRALS/AUTHORIZATIONS. We are required to follow the guidelines of your managed care plan. Prior to visiting a specialist, you must have a referral authorized from your primary care physician. Unless your referral is presented at the time of this visit, you are financially responsible for the services received. You will be given the option to reschedule your appointment without a cancellation fee. Otherwise without an authorized referral, payment is due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of that visit.

PATIENT BILLING. You will be sent three notices of your financial responsibility after payment and/or explanation of benefits (EOB) is received from your insurance company. After the third notice your account may be forwarded to collections with Westcoast Adjustors. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard and Discover. An additional $25.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, the patient, we will expect that you would forward it to our office to be applied to your balance.

PRIVACY STATEMENT. Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS.

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **DR. GRABOWSKI, PC** all insurance benefits for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

My signature confirms that I have read the above policy regarding my *financial responsibility* to Dr. Grabowski, PC. I agree to pay Dr. Grabowski, PC. in full any balance incurred by me or my dependent in the event that there is no health insurance coverage. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

FINANCIALLY RESPONSIBLE PARTY:

PATIENT: _____ _____ / /_____
Signature Print Date

GUARANTOR: _____ / /_____
Signature Print Date

Guarantor's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other