East End Foot & Ankle
Dr. Adam Didyk, DPM

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NEW PATIENT HISTORY INTAKE **Today's Date**_____

To our new patients: *Welcome* to East End Foot & Ankle. To help us establish you with our practice, please provide us with your complete health history. **To our established patients:** Thank you for returning and welcome back.

Patient Information

Full Name: _____Date of Birth:_____Age:_____

Email_____Race/ Ethnicity:_____

Social Security Number:_____ Preferred Language:_____Marital Status:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer Name and Occupation:_____

Primary Care Physician: _____ Date of Last Visit:_____

Were you referred by someone? _____ If yes, Who?:_____

How did you hear about our office?_____

Responsible Party- Financial Name, Date of Birth, Address, Social Security Number, and Relationship to Patient:

_____

Describe your foot and/or ankle problems, including right or left.

_____

Duration:_____Injury related? If yes, when?:_____

What treatment(s) have you received before your visit today?_____

Past Medical History and Family History Check all that apply:

	Yourself	Mother	Father		Yourself	Mother	Father
AIDS/HIV				High Blood Pressure			
Alcoholism				High Cholesterol			
Anemia				Kidney Disease			
Arthritis				Liver Disease			
Asthma/COPD				Sickle Cell Anemia			
Cancer				Acid Reflux			
Circulation Problems				Stomach Ulcers			
Diabetes				Depression/ Anxiety			
Heart Disease/Attack				Gout			
Heart Trouble				Fibromyalgia			
Hepatitis				Stroke			

Other not listed

Surgical History Include the date.

_____

_____

Height_____ Weight_____ Shoe Size_____

Medications: (Or indicate that list is attached)

_____ _____

_____ _____

Allergies. Please circle and indicate type of reaction. Include any not listed.

	Reaction		Reaction
Codeine/Hydrocodone		Sulfa Drugs	
Shellfish		Latex	
Adhesive Tape		Antihistamines	
Penicillin		Other:	

Pharmacy Name, Phone Number, and Location_____

Social History.

Current or Former Smoker – Circle one _____ Packs per day? _____ How long? _____

Do you drink alcohol? _____ Type: _____ Drinks per week: _____

Do you use recreational drugs? _____ Type: _____

Any type of exercise? Describe._____

Review of Systems. Check any that ***currently*** apply to you.

Constitutional:
__ poor appetite
__fever
__chills
__weight loss
__weight gain
__fatigue
__depression

HEENT:
__headaches
__wear glasses/contacts
__dizziness
__sore throat
__ sinus problems
__ seasonal allergies
__ringing in ears

Cardiovascular:
__chest pain
__palpitations
__ankle swelling
__varicose veins
__calf cramps

Respiratory:
__shortness of breath
__difficulty breathing
__cough

Skin:
__rash
__eczema
__itching

Musculoskeletal:
__neck/back pain
__hip/knee pain
__muscle weakness

GU:
__painful/frequent urination
__kidney stones

GI:
__nausea
__vomiting
__diarrhea
__heartburn
__abdominal pain

Neurological:
__loss of coordination
__seizures
__numbness in limbs
__tingling/burning in limbs

___**Please check here if all of the above symptoms are negative**.

I confirm that the above information is true and complete.

Sign: _____ Today's Date: _____

Financial Policy and Privacy Practices

Thank you for choosing Dr. Adam Didyk as your podiatrist. Please be advised our office has a few policies that you need to be aware of.

Please read and initial each item.

__1. If your insurance company requires a referral we require 7-10 days notice of your scheduled appointment. Emergency situations will be taken into consideration. The referrals can be faxed to us at (502) 426-4420. You will be responsible for making sure that the referral is received.

__2. All co-payments will be collected **prior** to service being rendered. All co-insurance and deductibles are payable after services are rendered. We accept most major credit cards, cash, and personal checks.

__3. Please bring in a list of your medications every time your medications have changed. We need to continuously update your chart. **You are responsible for informing our office of all insurance, address, employer and telephone number changes**.

__4. You will possibly be charged for a missed appointment. Please call **24 hours in advance** if you cannot keep the appointment.

I, the undersigned, hereby consent to any X-rays, diagnostic tests and treatment procedures considered advisable in the judgment of the physician on duty. I further consent to the release of information regarding my condition and treatment to my attorney and/or involved insurance companies. I authorize any insurance company and/or my attorney to disclose the status of my claim and/or the settlement agreement to East End Foot & Ankle (EEFA).

This medical history record has been designed to facilitate our patient's continuity of care at EEFA. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your documented authorization to do so. I understand I may be charged a reasonable cost-based fee should I need copies of certain medical records, such as X-rays. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

I, hereby, irrevocably assign, and transfer any and all medical benefits payable to me and further direct any insurance company from which I am entitled benefits to pay such medical benefits directly to EEFA. The undersigned agrees to be liable for any and all charges by EEFA including, but not limited to, any deductibles, copayments, and percentages as directed by my insurance company, or fees not paid by my insurance company. This Assignment does not release patient's obligation to such charges. EEFA will immediately file any insurance for which you are entitled benefits.

Any balance on my account not paid by my insurance carrier within 60 days will become my responsibility and understand I will be responsible for these payments. I understand that EEFA is unable to act as an intermediary between myself and my insurance carrier. I understand that I am responsible for contacting a customer service representative should I feel dissatisfied with my claim denial and feel my service should be covered. If, in error, my insurance company sends a check directly to me for payment of services received at this clinic, I agree to bring the misdirected check to this clinic within 48 hours.

I have read the above and agree to the terms.

Date **Patient/or Guardian signature** / **Date** **EEFA Representative Signature**