PREMIER PODIATRY EAST COBB

Trevor R. Beach, D.P.M. * I.Cristina Verlezza, D.P.M.

NEW PATIENT FORM

NAME:_____ **DATE OF BIRTH:** _____/_____/_____**AGE:**_____

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

Zip:_____ **Cell #**_____**Work #**_____**Home #** _____

Email_____**Preferred Method of communication?** Home / Cell / Email

I authorize Premier Podiatry to contact me via automated text/voice message/email to remind me of my upcoming appointments. I understand that message/data rates may apply. I know that I am under no obligation to authorize PP to send me appointment reminder texts/telephone calls. I may opt-out of receiving these communications at any time by calling us.

Gender: Male / Female / Decline to specify **Marital Status:** Single/Married /Divorced /Widowed **Occupation:**_____

Race: American Indian/ African American or Black/ Asian/ Hispanic or Latino/ White or Caucasian/ Decline to specify

Who referred you? Google / Yelp / Facebook / Sign / Internet / Insurance Company / Spouse / Friend / Dr_____

Emergency Contact_____ **Relationship**_____**Phone#**_____

Person (other than yourself or Emergency Contact) whom we may share your personal health information:

Name_____**Relationship**_____**Phone#**_____

Primary Care Physician _____**Phone#**_____

City_____**Last Visit**_____

PHARMACY _____ **Pharmacy #**_____

Pharmacy Address _____

INSURANCE INFORMATION

Insurance #1_____ **Insurance #2**_____

*If MEDICARE is your secondary insurance, please list reason why:*_____

PARTY RESPONSIBLE FOR BILL (other than yourself)

Name_____Relationship to Patient _____Phone#_____

ACKNOWLEDGMENT

- I certify the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and or ankles.
- I authorize the release of any medical information necessary to process claims. I further authorize payment of medical benefits directly to the physician for services rendered.
- Notice of Privacy Practices: I have read (or had the opportunity to read) and understand the HIPAA privacy and compliance practices maintained by Premier Podiatry-East Cobb.

SIGNATURE of Patient / Responsible Party_____

PRINTED name of patient / Responsible Party_____**Date**_____/_____/2024

Premier Podiatry-East Cobb
PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. A copy of this document is available upon request. If you have any questions, please discuss them with our front office staff.
PATIENTS MUST INITIAL ALL LINES AND PRINT/SIGN NAME AT THE BOTTOM OF THIS DOCUMENT.

- _____ *(Initial)* **All applicable co-pays, deductibles and co-insurance and/or non-covered services are due at time of service. These amounts are estimates given to us by your insurance company based on our contract with them. Once the claims have been adjudicated by your ins. company, there is a possibility that you may end up receiving a balance statement or a refund check.**
- _____ *(Initial)* **There are NO refunds or exchanges for supplies and medical equipment purchased in the office. ALL SALES ARE FINAL. NO EXCEPTIONS.** Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome.
- _____ *(Initial)* There is a **$25.00** fee for **no-shows** or **cancellations** made less than 24 hours in advance.
- _____ *(Initial)* **As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.**
- _____ *(Initial)* All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. ***We will attempt to verify benefits for some specialized services or referrals, however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.***
- _____ *(Initial)* **Your insurance policy is a contract between you and your insurance company.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- _____ *(Initial)* Your insurance company may request information from you before processing a claim, and it is your responsibility to comply with their request. **Failure to comply may result in denial of your claim, and you will be responsible for all charges incurred.**
- _____ *(Initial)* You **must** inform the office of all-insurance changes and authorizations/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- _____ *(Initial)* **For Workers Compensation patients:** we require a verified authorization from your insurance carrier prior to your initial visit. If your claim is denied you are responsible for payment in full.
- _____ *(Initial)* **Past due accounts** are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. **A 25% increase will be added to all patient accounts that are moved to a collection status.**
- _____ *(Initial)* There is a service fee of **$25.00** for **all returned checks.**

Signature of Patient/Responsible Party:_____**Date:**_____/____/2024

Printed Name of Patient/Responsible Party:_____

Referred by:_____

PREMIER PODIATRY EAST COBB

Today's Date: _____/_____/ 2024

BP _____/_____

PR_____

Trevor R. Beach, D.P.M. * I.Cristina Verlezza, D.P.M.

NAME:_____ **DATE OF BIRTH:** _____/_____/_____ **AGE:**_____

REASON FOR TODAY'S VISIT *(circle what applies)*

Heel Pain	Plantar Fasciitis	Ingrown Toenail
Warts	Neuroma *(Pinched nerve)*	Fractures
Nail Fungus	Athlete's foot	Bunion
Hammertoes	Callus	Ankle Pain

Other :_____

Pain Type: Aching / Throbbing / Shooting / Sharp / Stabbing

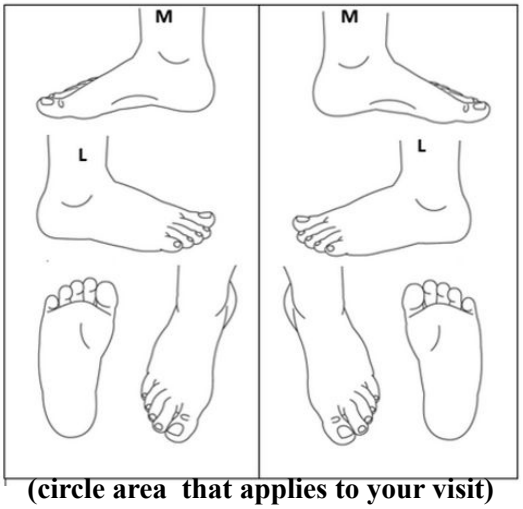
Pain Score: _____ (**0**-*No pain*; **10**- *The worst pain you have ever felt*)

When did this problem begin? _____

What caused it?_____

What types of treatment(s) have you tried?_____

What is your: ***Height*** _____ ***Shoe Size***_____ ***Weight***_____



(circle area that applies to your visit)

MEDICAL HISTORY *(Past and/or Current-Check to those that apply)*

○	Anemia	○	Depression	○	Hyperthyroidism	○	Sickle Cell Disease
○	Acid Reflux	○	Drug Abuse	○	Kidney Disease	○	Seizures
○	ADHD	○	Epilepsy	○	Liver Disease	○	Varicose Veins
○	Alcohol Abuse	○	Fibromyalgia	○	Lupus	○	Blood Clots - year: _____
○	Anxiety	○	Glaucoma	○	Migraines	○	Heart Problems - Specify:_____
○	Asthma	○	Gout	○	Osteoarthritis	○	Stroke - year_____
○	Auto Immune Disease	○	High Blood Pressure	○	Osteoporosis	○	Cancer - Type: _____Year:_____
○	Blood Disorders	○	High Cholesterol	○	Psoriasis		
○	Cataracts	○	Hepatitis A, B, C	○	Peripheral Vascular Disease	○	Diabetes - Circle: Type I or II - for_____ yrs?
○	Charcot Joint	○	HIV/AIDS	○	Rheumatoid Arthritis	○	Neuropathy
○	Cramps-Leg/foot	○	Hypothyroidism	○	Stomach Ulcers		

Other:_____

IF DIABETIC

Doctor who manages your diabetes? _____ ***City***_____

Date last seen_____/_____/ 20____ ***Blood Glucose this Morning***_____ ***Last Hemoglobin A1C*** _____

Last Eye exam *(mm/dd/yy)*_____/_____/_____ ***Any of these symptoms in your feet?*** Tingling / Numbness / Burning

SURGICAL HISTORY *(Check those that apply)*

		Year			Year			Year			Year
○	Angioplasty		○	Carotid Artery		○	Hernia repair		○	Vein Ligation	
○	Appendectomy		○	Cataract		○	Kidney surgery		○	Foot surgery	
○	Ankle surgery		○	D & C		○	Mastectomy		○	Metal in Body	
○	Arterial By-pass		○	Gallbladder Surg		○	Heart surgery		○	Pacemaker	
○	Back surgery		○	Hysterectomy		○	Prostate surgery		○		
○	Breast Biopsy		○	Hip surgery		○	Tonsillectomy		○		
○	C-section		○	Knee Surgery		○	Stents (heart/legs)		○		

Other:_____

ALLERGIES *(Check those that apply)*

◯	**No Known Drug Allergies**

		Reaction
◯	Aspirin	
◯	Anesthetics	
◯	Adhesive/Tape	
◯	Codeine	

		Reaction
◯	Cortisone	
◯	Iodine/Betadine	
◯	Latex	
◯	Penicillin	

		Reaction
◯	Sulfa	
◯	Shellfish	

Other:_____

FAMILY HISTORY *(Circle if it applies)*

Mother	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:
Father	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:
Siblings	Diabetes	Heart Disease	High Blood Pressure	Cancer - Type:

SOCIAL HISTORY *(Check those that apply and explain)*

	No	**Yes**		
Do you drink alcohol?			*If yes, how much?*	
Any illicit drug use?			*If yes, explain*	
Do you smoke?			*If yes, how much?*	
Did you ever smoke?			*If yes, for how long?*	*If yes, when did you quit?*
Are you pregnant?			*If yes, how far are you?*	

ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING? *(Circle what applies):*

GENERAL	Fever	Chills	Diarrhea	Nausea/Vomiting
HEAD & EYE	Dizziness	Headaches	Double vision	Fainting
EAR/NOSE/THROAT	Hearing Loss	Sinus problems	Tinnitus	Hoarseness
RESPIRATORY	Asthma	Bronchitis	Shortness of breath	Emphysema
GASTROINTESTINAL	Heartburn	Diarrhea	Vomiting	Ulcers
URINARY	Incontinence	Blood in urine	Painful urination	Frequent urination
MUSCULOSKELETAL	Muscle aches	Weakness	Swollen joints	Back pain
SKIN	Rash	Itching	Dryness	Sores
NEUROLOGICAL	Numbness	Tics	Paralysis	Tremors
ENDOCRINE	Excessive hunger	Excessive Sweating	Excessive thirst	

MEDICATIONS

Name of Medication	**Dosage (mg)**	**How many times per day?**

I ACKNOWLEDGE THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TRUTHFULLY & COMPLETELY TO THE BEST OF MY KNOWLEDGE & RECOLLECTION.

SIGNATURE_____ **DATE** _____/_____/**2024**