



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 ____ / ____ /2023

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: ____/____/2023

Printed Name of Patient/Responsible Party: _____

Referred by: _____



Today's Date: ____/____/2023

BP ____/____

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

PR ____

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

REASON FOR TODAY'S VISIT (circle what applies)

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

Other : _____

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

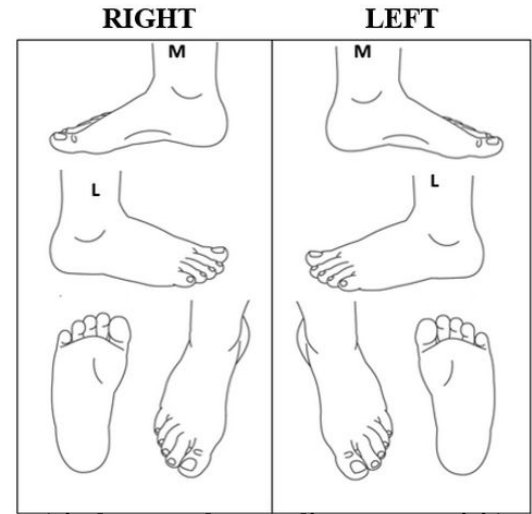
Pain Score: _____ (0-No pain; 10- The worst pain you have ever felt)

When did this problem begin? _____

What caused it? _____

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

What is your: Height _____ Shoe Size _____ Weight _____



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

<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> ADHD	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Blood Clots - year: _____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraines	<input type="checkbox"/> Heart Problems - Specify: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Stroke - year _____
<input type="checkbox"/> Auto Immune Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Cancer - Type: _____ Year: _____
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Diabetes - Circle: Type I or II - for _____ yrs?
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Charcot Joint	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Cramps-Leg/foot	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> 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
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Carotid Artery	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Vein Ligation
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cataract	<input type="checkbox"/> Kidney surgery	<input type="checkbox"/> Foot surgery
<input type="checkbox"/> Ankle surgery	<input type="checkbox"/> D & C	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Metal in Body
<input type="checkbox"/> Arterial By-pass	<input type="checkbox"/> Gallbladder Surg	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Prostate surgery	
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Hip surgery	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> C-section	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Stents (heart/legs)	

Other: _____

ALLERGIES (Check those that apply)

No Known Drug Allergies

Reaction	
<input type="radio"/>	Aspirin
<input type="radio"/>	Anesthetics
<input type="radio"/>	Adhesive/Tape
<input type="radio"/>	Codeine

Reaction	
<input type="radio"/>	Cortisone
<input type="radio"/>	Iodine/Betadine
<input type="radio"/>	Latex
<input type="radio"/>	Penicillin

Reaction	
<input type="radio"/>	Sulfa
<input type="radio"/>	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** ____ / ____ /2023