Dwight S. Blease, DPM
Casco Bay Podiatry - Active Foot & Ankle
10 Cushing Street, Brunswick, ME 04011
207-725-2800 / fax 207-725-5953

Welcome to the Office!

REASON FOR TODAY'S VISIT:

_____
_____

TODAY'S DATE: _____ - _____ - _____

_____ D.O.B. _____ - _____ - _____
Last Name *First Name* *MI* Age: _____

Preferred Name: _____ Gender: F / M Social Security #: _____ - _____ - _____

Address: _____
Street *City/Town* *State* *Zip Code*

Phone: Home: _____
Work: _____
Cell: _____
Email: _____

Primary Care Physician: _____
PCP Address: _____
Pharmacy Name: _____
Pharmacy Location: _____

Occupation: _____ Employment: [ ]Full-Time [ ]Part-Time [ ]Self-Employed [ ]Retired [ ]Unemployed
Employer: _____ Job Duties: _____

Marital Status: [ ] Married [ ] Single [ ] Partner [ ] Separated [ ] Divorced [ ] Widowed

Please answer the following ETHNICITY question, part of a federal mandate
RACE: [ ] WHITE [ ] BLACK/AFRICAN AMERICAN [ ] AMERICAN INDIAN [ ] ASIAN [ ] HISPANIC/LATINO/SPANISH
[ ] OTHER _____ (please specify) [ ] I DECLINE

Emergency Contact: _____ Home Phone: _____
Relationship: _____ Cell Phone: _____

Guarantor
(Person responsible for paying the bills)

Patient's Relationship to Guarantor: [ ]Self [ ]Spouse [ ]Employee [ ]Child (Father's Insurance) [ ]Child (Mother's Insurance)
Other (Please Explain): _____

Guarantor Last Name: _____
Guarantor First Name: _____ M.I. _____
Guarantor D.O.B. _____ - _____ - _____
Guarantor Address (for billing purposes): _____
Street *City* *State* *Zip Code*

Insurance Policy Holder
(If different from Patient)

Patient's Relationship to Policy Holder: [ ]Self [ ]Spouse [ ]Employee [ ]Child (Father's Insurance) [ ]Child (Mother's Insurance)
Other (Please Explain): _____

Policy Holder's Last Name: _____
Policy Holder's Name: _____ M.I. _____
Policy Holder's D.O.B. _____ - _____ - _____
Policy Holder's Address: _____
Street *City* *State* *Zip Code*

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PATIENT NAME: _____

Patient Medical History

CONDITION	SELF	FAMILY	IF FAMILY, WHO?
Arthritis			
Cancer: type:			
Cardiovascular:			
Atrial Fibrillation (Afib)			
Chest Pain			
Congestive Heart Failure			
Heart Attack			
High Blood Pressure			
Mitral Valve Prolapse			
Stroke/TIA			
Pacemaker			
Palpitations/Arrhythmia			
Endocrine:			
Diabetes (insulin)			
Diabetes (non-insulin)			
Avg. Blood Sugar:			
Avg. A1C:			
Thyroid Disease			
Eye Disease:			
Gout			
Gastrointestinal:			
Crohn's Disease			
GERD (Reflux/Heartburn)			
Hematologic/Lymphatic:			
Anemia			
Bleeding Disorders			
DVT/Blood Clotting/PE			
Infections:			
MRSA			
Infectious Disease:			
Hepatitis			
Herpes			
HIV/AIDS			
Infectious Skin Infection			

CONDITION	SELF	FAMILY	IF FAMILY, WHO?
Kidney Disease:			
Kidney Failure			
Dialysis			
Liver Disease:			
Hepatitis A, B, or C			
Lung Disease:			
Asthma			
COPD			
Emphysema			
Shortness of Breath			
Tuberculosis			
Memory Loss			
Musculoskeletal:			
Back Pain			
Fibromyalgia			
Joint Pain/Swelling			
Leg Cramps			
Morning Stiffness			
Muscular Tenderness			
Neck Pain			
Osteoporosis			
Stiffness			
Weakness of Muscles			
Difficulty with Walking			
Neurological (Nerve Issues):			
Seizure Disorder			
Tremors			
Multiple Sclerosis			
Numbness			
Parkinson's Disease			
Burning in Feet			
Tingling in Feet or Toes			
Prostate			
Psychiatric			

Medications (please list or provide a copy)

Are you Allergic or Sensitive to? [ ] No Known Allergies

[ ] Penicillin [ ] Sulfa [ ] Vicodin [ ] Codeine [ ] Iodine

[ ] Tape [ ] Latex [ ] Other Allergies (list): _____

_____

Surgeries	Year	Hospital & Surgeon

Do you smoke cigarettes? Y / N [ ] ½ pack/day [ ]1 pack/day [ ]1 ½ packs/day [ ]2 packs/day [ ] >2 packs/day [ ] Cigars [ ] Pipe [ ] Chewing Tobacco

If NO, did you smoke in the past? Y / N If yes, how many years did you smoke? _____ Quit year? _____

Do you drink alcohol? Y / N [ ] Socially [ ] 1 Daily [ ] 2 Daily [ ] 3 Daily [ ] >3 Daily Preferred Beverage(s): _____

How often do you exercise? [ ] Rarely/Occasionally [ ] 1-2 Times a week [ ] 3-4 Times a week [ ] 5-6 Times a week [ ] Daily

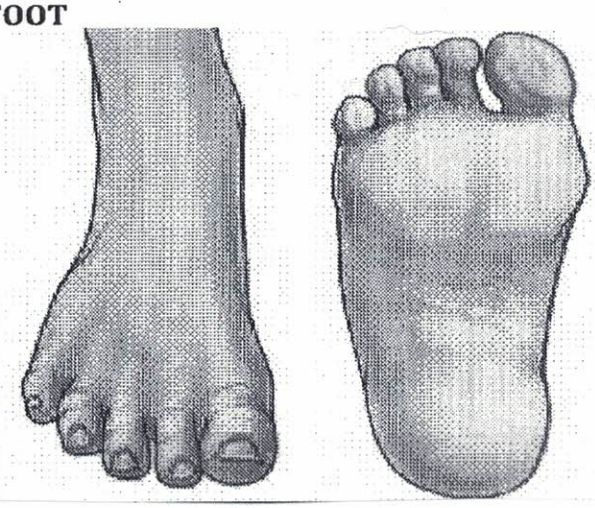
Describe your exercise routine: _____

_____ If walking, running, or cycling how far do you go in a week? _____

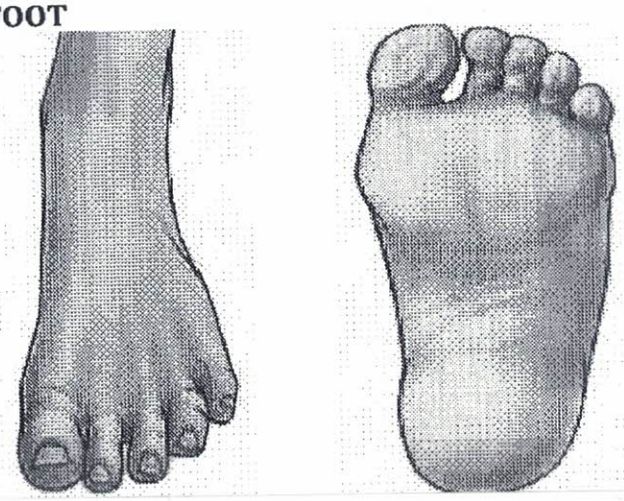
TODAY'S DATE: _____

Current Chief Complaint/History of Present Illness

RIGHT FOOT



LEFT FOOT



Indicate the location of your problem or pain on the diagrams above.

Describe the pain: Sharp Dull Aching Throbbing Burning Shooting Stabbing Electrical

Indicate the severity of pain/discomfort

☐None ☐Light ☐Moderate ☐Strong ☐Severe

Please indicate pain level 0 1 2 3 4 5 6 7 8 9 10

How long ago did pain/discomfort start?

☐Years ☐Months ☐Weeks ☐Days ☐Hours

Pain occurs while

☐Walking ☐Standing ☐Running ☐Wearing Shoes ☐At Rest ☐All the Time

Does the pain/discomfort cause difficulty with daily activity?

Is this problem work related? ☐Yes ☐No

SHOE SIZE:

HEIGHT:

WEIGHT:

BLOOD PRESSURE:

PULSE:

TEMP:

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Office Policies

Your understanding of our policies is an essential element of your care and treatment. If you have any questions, please discuss them with us.

Referrals/Authorizations: As our patient, you are responsible for obtaining *and* renewing all referrals or authorizations needed to seek treatment in this office. Please contact your insurance provider with any coverage questions. INITIALS_____

Insurance(s): You must inform the office of all insurance changes. In the event the office is not informed of a change, you will be responsible for all charges denied. INITIALS_____

Non Covered Services: In the event your health plan determines a service to be "not covered," or not authorized, you will be responsible for the complete charge. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. Some non-covered items are: arch supports, orthotics and surgical boots. *Medicare Plans (and replacements) have their own rules regarding "routine foot care". Only under certain medical conditions are nails, corn and callus trimmings paid for by insurance. Please talk to the doctor for clarification regarding your situation.* INITIALS_____

Cancellations: We ask for 48 business hours' notice when cancelling an appointment. No- shows or cancellations with ***less than 24 hours'*** notice will result in an office charge of $50.00. You will be asked to pay this before you are next seen by the doctor. INITIALS_____

Copay: Your insurance policy is a contract between you and your insurance company. *Copays are due at the time of the visit.* As a courtesy, we file your insurance claims for you. INITIALS_____

Returned Checks: There is a service fee of $40.00 for all returned checks. INITIALS_____

Payments: We accept Cash, Check, Visa, MC, and Discover. 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 to the office. INITIALS_____

Medicare: I authorize the release of any information necessary to process medical claims for Casco Bay Podiatry and authorize that payment of Medicare benefits for these claims be made to this office. Also, I agree to pay promptly for any services not covered by Medicare and or determined by Medicare to be my responsibility (i.e., Deductibles, Co-payments dictated by Medicare such as 20% of the allowable fee for Medical Services and any charges for Services not covered or deemed "Not Reasonable and Necessary" by Medicare). INITIALS_____

Patient/Guardian Signature:_____ Date:_____

Name Printed:_____ If not patient, relationship:_____

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PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Casco Bay Podiatry to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any coinsurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Medicare: I authorize the release of any information necessary to process medical claims for Casco Bay Podiatry and authorize that payment of Medicare benefits for these claims be made to this office. Also, I agree to pay promptly for any services not covered by Medicare and or determined by Medicare to be my responsibility (i.e., Deductibles, Co-payments dictated by Medicare such as 20% of the allowable fee for Medical Services and any charges for Services not covered or deemed "Not Reasonable and Necessary" by Medicare).

Consent and acknowledgement of Medical Privacy Notice: It is the policy of Casco Bay Podiatry that health care information is confidential and shall not be improperly disclosed. Your healthcare information shall not be disclosed unless disclosure is permitted or required by law, or you have specifically authorized the disclosure. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement. I am entitled to a copy of this consent upon request.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian Signature: _____ Date: _____

Name Printed: _____

If not patient, relationship _____