M Derek Smith DPM

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www.mdereksmithdpm.com.com

To Our New Patient:

Welcome to M. Derek Smith DPM! We are thrilled that you have chosen our team for your foot and ankle needs. We will do our best to provide you with the most up-to-date and comprehensive podiatric care available. We have a total commitment to keeping your feet healthy – and keeping you happy.

To maximize your time with us, we ask that you bring the following to your first visit; photo identification, medical insurance card(s), written referral (if required by your insurance company), and prior medical records and a list of medications. If you are having foot/heel pain, please bring or wear a lace up type shoe (example tennis shoes). If you have an infected toenail, bring or wear a pair of open toe shoes (example slides).

In addition, please complete and sign the New Patient Forms included with this letter. These include our Patient Registration, Comprehensive Health Review (include all current medications and dosages), Consent to Treatment, Financial Policy, and Privacy Practices.

Whether you have a serious foot health condition or you're just looking for added comfort, M. Derek Smith DPM is here to provide the best podiatric care possible. We look forward to your appointment with us!

Sincerely,

M. Derek Smith DPM

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name / First / Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy) / Sex ☐ M ☐ F	Spouse's Name
Street Address	Social Security #	Home Phone # ( )
City / State / Zip Code	E-Mail	Mobile Phone # ( )
Primary Care Doctor	Last Date of Service: / /	Employer/Work Phone # ( )
Employer	How Did You Hear About Us	

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy) / Sex ☐ M ☐ F	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Street Address	Social Security #	Home Phone # ( )
City / State / Zip Code	E-Mail	Mobile Phone # ( )
Employer	Employer Address	Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

PHARMACY INFORMATION

Pharmacy Name & Address: ______________________________

☐ CVS ☐ Rite-Aid ☐ Walgreens ☐ Target Other ____________ ☐ Phone Number ____________

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to M. Derek Smith DPM all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. M. Derek Smith DPM may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X ______________________________

PATIENT/GUARDIAN SIGNATURE DATE

COMPREHENSIVE HEALTH REVIEW

Patient Name: ________________________________

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	Dosage	Medication	Dosage

ALLERGIES

- ☐ None
- ☐ Adhesives/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafood/Shellfish
- ☐ Sulfa Drugs
- ☐ ________________

SOCIAL HISTORY

Occupation: ________________________________

☐ I Drink Alcoholic Beverages How much/often?____________

☐ I Use or Have Used Tobacco Products Type:____________

Packs/Day________ Years________When Stopped? ________

☐ I Use or Have Used Drugs that are Illegal ____________

I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand______% of My Day

I Exercise Each Week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

List Sports/Activities: ________________________________

____

____

☐ My foot/ankle problem limits my activities

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Changes
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue

EYES
- ☐ Eye Disease/Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double vision
- ☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Arrhythmia/Irregular Heart Beat
- ☐ Leg Pain when Walking
- ☐ Swelling of Hands/Feet

MUSCULOSKELETAL
- ☐ Muscle Pain or Cramps
- ☐ Joint Pain
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking

GASTROINTESTINAL
- ☐ Indigestion/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

INTEGUMENTARY
- ☐ Rash or Itching
- ☐ Dry Skin
- ☐ Change in Hair/Nails

HEMATOLOGICAL
- ☐ Bruise Easily
- ☐ Slow to Heal

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold

NEUROLOGICAL
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Confusion/Memory Loss

STATS

Age ______ Height ________ Weight ________ Shoe Size _______

For Office Staff

BMI ________

BP_________P__________O2 Sat___________Temp _________

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive the best possible care.

X ________________________________ ____________________

PATIENT/GUARDIAN SIGNATURE DATE

COMPREHENSIVE HEALTH REVIEW

Patient Name:______________________________ Date of Birth:______________ Today's Date: ______________

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? ______________________________

Which foot/ankle is involved? □ Right □ Left □ Both

First visit to a doctor for this problem? □ Yes □ No

Have you had a similar problem in the past? □ Yes □ No

When did the problem begin? ______________

How was the problem onset? □ Sudden □ Gradual

The problem is: □ Improving □ Worsening □ Unchanged

The problem is worst: □ AM □ PM □ At Rest □ With Activity

What aggravates the problem? ______________

What improves the problem? ______________

Is the problem painful? □ Yes □ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: □ Sharp □ Dull □ Aching □ Throbbing □ Cramping □ Itching □ Popping □ Burning □ Tingling □ Clicking □ Shooting □ Stabbing □ Other: ______________

Describe previous treatments: ______________________________

Is this from an injury? □ Yes □ No If so, is it work-related? □ Yes □ No ______________

PAST MEDICAL HISTORY

- □ Diabetes Type 1 2 Duration _____years Last Blood Sugar______HbA1c______
- □ Acid Reflux
- □ Anemia
- □ Anesthesia Complications
- □ Arthritis (□ Osteo / □ Rheum)
- □ Asthma
- □ Back Problems/Sciatica
- □ Blood Clot/DVT
- □ Cancer: ______________
- □ Cellulitis/Skin Infection (□ MRSA?)
- □ Circulation Problem
- □ Dementia/Alzheimer's
- □ Excessive/Easy Bleeding
- □ Fibromyalgia
- □ Foot/Leg Ulcer
- □ Gout
- □ Healing Problems/Keloids
- □ Heart Disease/Heart Attack
- □ High Blood Pressure (□ Low BP?)
- □ High Cholesterol
- □ Hormone Therapy
- □ Immune Disorder/HIV
- □ Kidney Disease (□ Dialysis)
- □ Other problems not listed: ______________________________
- □ Liver Disease (□ Hepatitis)
- □ Leg Cramps/Leg Pain at Rest
- □ Lung Condition:______________
- □ Mitral Valve Prolapse/Murmur
- □ Multiple Sclerosis
- □ Nervous Disorder/Depression
- □ Neuropathy
- □ Osteomyelitis/Bone Infection
- □ Parkinson's Disease
- □ Previous Addiction to:______________
- □ Pulmonary Embolism
- □ Rashes/Skin Condition
- □ Raynauds Disease/Phenomena
- □ Seizure Disorder/Epilepsy
- □ Sickle Cell Disease/Trait
- □ Sleep Apnea
- □ Stomach Ulcers
- □ Stroke □ Rt □ Lt (year______)
- □ Thyroid Condition (□ Hi □ Lo)
- □ Varicose Veins
- □ Women – Are You Pregnant or Breast Feeding?

PAST SURGERIES

- □ Foot/Ankle Surgery: ______________
- □ Joint Replacement: ______________
- □ Open Heart/Bypass Surgery
- □ Hysterectomy □ Tubal ligation □ C-Section
- □ Stent Placement: Heart Leg
- □ Cosmetic Surgery: ______________
- □ Appendix □ Gallbladder □ Tonsils/Add
- □ Leg Bypass □ Open Fracture Repair
- □ Carotid Surgery □ Vein Surgery
- □ Hernia repair □ Thyroid □ Back surgery
- □ Other: ______________

FAMILY HISTORY (circle relative)

Mother Father Sister Brother GrandParent

Condition	Relative
□ Cancer	M F S B GP
□ Diabetes	M F S B GP
□ Gout	M F S B GP
□ Heart Disease	M F S B GP
□ High Blood Pressure	M F S B GP
□ Severe Arthritis	M F S B GP
□ Anesthesia Complications	M F S B GP
□ Foot Problems	M F S B GP
□ Other: ______________	M F S B GP

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the M. Derek Smith DPM Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: ________

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize M. Derek Smith DPM to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: ________

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the M. Derek Smith DPM and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: ________

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize M. Derek Smith DPM to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at M. Derek Smith DPM and it may include prescriptions back in time for several years.

Patient Initials: ________

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by a M. Derek Smith DPM, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the M. Derek Smith DPM. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: ________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to M. Derek Smith DPM, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Patient Initials: ________

M. Derek Smith DPM may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: ________

DISCLOSURE OF SERVICES

I understand that M. Derek Smith DPM is owned and operated by Dr M. Derek Smith. During my course of treatment, products may be recommended. I understand that I am under no obligation to purchase these products and that i may find alternate sources to purchase these products.

Patient Initials: ________

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a M. Derek Smith DPM patient. I have read this complete page and agree to all of its contents.

______________________________	______________________________	______________
Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date

FINANCIAL POLICY

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

1. COPAYMENTS: **It is a requirement of your insurance company that we collect your co-pay.** Payment is required before meeting with the doctor. Dr. Smith is a Specialist so if there is a different copay for Specialist that will be the amount that is collected. Patient Initials: ________

2. DEDUCTIBLES & CO-INSURANCE: Some insurance plans do not have a copay but instead the office visit is subject to deductibles and coins. The following are also subject to your Deductible and Coinsurance if it is considered a covered service by your insurance and are not included in an office visit; Patient Initials: ________
   - **Procedures** (examples; wart chemical cautery, wart extraction, permanent nail Removal, temporary Nail Removal, ulcer debridement)
   - **Xrays**
   - Most **durable medical equipment**

3. You will be notified before the procedure, service, or dispensing of durable medical equipment of the costs per your insurance allowable before proceeding with treatments or dispensing of products. **Payment is expected at time of service.** Patient Initials: ________

4. SELF-PAY: Full payment is due at time of service. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor, but you will be informed of these charges before proceeding with treatment. Patient Initials: ________

5. REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment. Patient Initials: ________

6. NO SHOW: 24 hours notice is required for cancellation of your appointment and failure to do so will incur a $50 fee. Failure to provide 24 hours notice of a procedural visit will incur a $100 fee. Patient Initials: ________

7. SURGERY CANCELLATION: Failure to provide 5 business days notice of cancellation prior to scheduled surgery date will incur a $500 fee. Patient Initials: ________

8. BALANCES/COLLECTION FEES: If balance is not collected within 30 days from the postmark date of a mailed statement, a $12 re-billing is fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a 33 1/3% administrative fee will be added. We accept cash, checks, all major credit cards and for convenience, payments can be made mail or calling our office. If you have a past due balance, you will be asked to pay half of the balance at your next appointment and be required to keep a credit card on file with our office. Patient Initials: ________

9. FMLA/DISABILITY/MEDICAL RECORDS: There is a $25 charge for completion of these forms. There is a $10 fee to obtain a copy of your medical records. Patient Initials: ________