Medicare Patient Enrollment Sheet

PATIENT INFORMATION:

LAST NAME_____________________________FIRST NAME______________________________ MIDDLE INIT.______

STREET______________________________ CITY_________________________ STATE________ ZIP______________

SSN_________________________________ DOB_____/______/______ MALE / FEMALE

HOME PHONE_____________________________ CELL PHONE__________________________________

WORK PHONE_____________________________ E-MAIL ADDRESS _____________________________________

EMPLOYER____YOUR OCCUPATION ____________________________

Primary Care Doctor__________________________________ Primary Doctor Phone ___________________________

How did you hear about our office? ☐ Insurance Directory ☐ Website ☐ Yellow Pages ☐ TV/Radio

☐ Referred by Physician (name) __________________________ ☐ Referred by friend _______________________

(do not repeat if same as above)

RESPONSIBLE PARTY:

RELATIONSHIP TO PATIENT___________________________

LAST NAME_____________________________FIRST NAME______________________________ MIDDLE INIT.______

STREET______________________________ CITY_________________________ STATE________ ZIP______________

SSN_________________________________ DOB_____/______/______ MALE / FEMALE

HOME PHONE_________________________________ CELL PHONE__________________________________

INSURANCE INFORMATION (COPIES OF FRONT AND BACK OF INSURANCE CARDS)

PRIMARY INSURANCE_______________________________ POLICY NO. _____________________________________

SUBSCRIBER____ DOB ____/_____/______

SECONDARY INSURANCE_______________________________ POLICY NO. ___________________________________

SUBSCRIBER____ DOB ____/_____/______

PLEASE READ AND SIGN [I HEARBY GIVE MY PERMISSION TO THE DOCTORS OF MID-WEST PODIATRY & ASSOCIATES, LLC TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. I HEARBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MID-WEST PODIATRY & ASSOCIATES, LLC AND THE RELEASE OF ANY INFORMATION REQUIRED BY THIRD PARTY PAYORS IN CLAIM PROCESSING AND UNDERSTAND THAT I AM FINANCALLY RESPONSIBLE FOR ANY REMAINING BALANCE.]

____

SIGNATURE (PATIENT/RESPONSIBLE PARTY) DATE

form updated 06/11/2019

Medicare part B has designed a dual purpose Medicare/Medigap card for signature on file requirements. Providers may duplicate the form below and use it to obtain a "signature on File" for both Medicare and Medigap. Please remember that you must get approval from Medicare Part B to use the signature on file method of billing.

_____________________ _____________________

Name of Patient HIC#

_____________________ _____________________

Name of Medigap Insurer Medigap Policy #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (enter provider name) for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

_________________________ ______________________________

Patient's Signature Date Signed

Podiatry History (Please Print)

Primary reason for today's visit: Describe any Pain or disability ____
____
____

Which side: Left | Right | Both **Rate your pain on a scale of 1 - 10** (1 is no pain)__________________

Have you been to a podiatrist before? Yes | No Dr.__________________ Last Seen ___________

Is this a work related injury? Yes | No If yes, has your employer been notified? Yes | No

☐ **Check if No Known Allergies**

Allergy	Yes	Reaction	Allergy	Yes	Reaction
Adhesive/Tape			Novacaine		
Aspirin			Penicillin		
Codeine			Shell Fish		
Iodine			Sulfa Drugs		
Latex			X-Ray Dye		
Other:					

Current Medications ☐ See attached list **OR** List medications and dosage below

Medication	Dosage	Medication	Dosage

Pharmacy:__________________ **Address:**__________________________ **Phone:**_______________

Medical History

Check YES below if you are currently being treated for OR have been treated for in the past.

Problem	Yes	Problem	Yes	Problem	Yes
Anxiety		Heart Attack		Psoriasis	
Arthritis		Heart Disease		Psychiatric	
Asthma		Hepatitis (A B C)		Pulmonary Embolism	
Cancer (specify below)		High Blood Pressure		Rheumatoid Arthritis	
Diabetes (type I or II)		High Cholesterol		Seizure Disorders/ Epilepsy	
Emphysema		HIV/AIDS		Stomach Ulcer	
Fibromyalgia		Kidney Disease		Stroke/ TIA	
GERD (acid reflux)		Mitral Valve Prolapse		Thyroid Disorder	
Other:					

Last Name______________________________ **First Name**____________________ **Middle Initial** ____

Previous Surgeries

____

____

____

Social History

	Yes	No	Only in Past	**Current Employment Status**	Yes	No
Drink Alcohol				Are you currently employed?		
Use Illegal Drugs				How many hours do you stand at work (daily)?		
Tobacco Use				What type of work do you do?		

Family History

Condition	Yes	Relationship	Condition	Yes	Relationship
Diabetes					
Heart Disease					
Foot Problems					

Review of Systems

Check YES next to any symptoms you are currently experiencing.

Symptom	Yes	**Symptom**	Yes	**Symptom**	Yes
Back Pain		Fatigue		Numbness/Tingling	
Bleeding Problems		Fever		Ringing in the ears	
Chest Pain		Headaches/Migraines		Skin Problems	
Chills		Heartburn/Indigestion		Swelling	
Difficulty Breathing		Joint Discomfort/Pain		Urinary Problems	
Dizziness		Muscle Pain		Excessive Weight Gain	
Eye/Vision Problems		Nose Bleeds		Excessive Weight Loss	
Other:					

Consent for Treatment

I certify that all the above information is true and correct to the best of my knowledge. I give permission to the doctor and his/her assistants to administer and perform such procedures as may be deemed necessary the diagnosis and/or treatment of my podiatric condition(s).

____ ________________________

SIgnature of Patient or Authorized Representative Date

To be completed by the physician:

I have reviewed this patient information document

____ ________________________

SIgnature of Physician Date

Last Name________________________________ **First Name**______________________ **Middle Initial** ____

form updated 06/11/2019

Patient Name______________________________________ Age ____________ Date_____________

Demographics

What is your primary language?	□ English □ Spanish □Other ____	□ Decline to answer
What is your race?	□ American Indian or Alaska Native □ Asian □ Black/African American □ Caucasian □ Native Hawaiian or Other Pacific Islander	□ Decline to answer
What is your ethnicity?	□ Hispanic or Latino □ Not Hispanic or Latino	□ Decline to answer

□ History of Diabetes

□ History of High Blood Pressure

□ No History of Diabetes or Hypertension

Smoking Status:

□ **Current Smoker** *Every Day* (Patient smokes every day)

□ **Current Smoker** *Some Day* (Patient smokes infrequently but has smoked more than 100 cigarettes)

□ **Current Smoker** *Unknown* (Patient is unable or refuses to quantify how much they smoke)

□ **Former Smoker** (Patient was a "Current Smoker" in the past, but no longer smokes)

□ **Never a Smoker** (Patient has smoked less than the equivalent of 100 cigarettes in his/her life)

□ **Unknown if ever smoked** (patient is unable or refuses to answer)

For Office Use Only

Height ______ inches **Weight** ______lbs **BMI**_______

Blood Pressure ______/______mm/Hg **Pulse**________ bpm

Temp ______° F **Shoe Size**____________

HbA1c (for diabetics only) __________

Office Signature____

Mid-West Podiatry & Associates, LLC

Permissions for releasing information

In order to make communications concerning appointments, treatment and billing matters easier, law requires your consent to release personal and health information.
Please list specific names of family members and/or friends that have your permission to obtain information from this office regarding your care and personal information.

NAME	RELATIONSHIP	PHONE NUMBER
______________________	_______________	______________________
______________________	_______________	______________________
______________________	_______________	______________________
______________________	_______________	______________________

I give my permission to leave a message on my:

_____________ Home answering machine   __________ Work voicemail

_____________ Cell phone   __________ E-mail

Patient Name: ____

Signature: ____

Date: ____

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*Signature of patient representative if patient is a minor or an adult unable to sign.

*Relationship to Patient:____________________________________

form updated 06/11/2019

Mid-West Podiatry & Associates, LLC

Acknowledgment of Receipt of
Notice of Privacy Practices

I, ____, have received a copy of this office's updated Notice of Privacy Practices.

____Signature of patient or parent/legal guardian/legally responsible person

____
Description of relationship to the patient

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual/Representative refused to sign the form
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify)

____

____

____

form updated 06/11/2019

PODIATRIC INFORMATION SHEET

NAME:________________________________TODAY'S DATE:__________________

DATE OF BIRTH:__________________

PRIMARY CARE PHYSICIAN'S NAME: ____

Has your address, telephone number, or insurance changed since your last visit here? **YES or NO**

ARE YOU DIABETIC? YES or NO

If yes: PHYSICIAN TREATING YOUR DIABETES: _________________________________

(*This cannot be a Nurse Practitioner or Physician's Assistant)* DATE LAST SEEN:______________

MEDICARE DOES NOT COVER ROUTINE FOOT CARE.
MEDICARE COVERS TREATMENT OF MYCOTIC (Fungal) NAILS EVERY 60 DAYS WHEN:

1. You have a systemic disease (i.e., diabetes, atherosclerosis), and certain class findings are present. Please discuss with your doctor.
2. When you do not have a systemic disease but there is clinical evidence of mycosis present AND one of the following is present:
   a. Pain
   b. Secondary infection associated with the fungal nails
   c. Marked limitation of ambulation

In order to help us determine if your nail care is a covered service under Medicare guidelines, **please answer the following questions:**

1. Do you have conditions such as diabetes, poor circulation, or numbness in your feet currently being treated by your primary care physician? **YES or NO**

2. Are your toenails affecting your ability to walk? **YES or NO**

3. Are your toenails causing you pain or discomfort? **YES or NO**

4. Do you have pain or infection in your lower limb? **YES or NO**
   If Yes, please describe:
   ____

5. Do you have pain when wearing shoe gear, pain when walking, tenderness, redness, drainage, other? **YES or NO**
   If Yes, please describe:
   ____

Signature:____

Date:________________

form updated 06/11/2019

Podiatric Information Sheet

PQRS

Patient Name______________________________ Date____________

E-Mail Address______________________________________

1. If you are diabetic, what was your last HBa1C ___________

2. Have you had a Pneumonia vaccine?

   YES or NO

3. Have you had a influenza shot between October 1st and March 31st?

   YES or NO

4. Do you use tobacco products?

   YES or NO

5. Has your doctor prescribed medication to treat high blood pressure (hypertension)?

   YES or NO

6. Do you have an advanced care plan or surrogate decision maker?

   YES or NO

   If you have a surrogate decision maker, who is it? ______________________________

7. Have your medications changed?

   YES or No

   If yes, please provide a list

form updated 06/11/2019