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taubpodiatry.com

Welcome to Taub Podiatry

Thank your for choosing our office for your foot and ankle care. We strive to provide you with efficient and curteous attention at each of your visits. We respect your time and make every effort to see you at your appointed time. It is our hope that the following information will answer any questions that you may have about our office, if you have any questions, please feel free to ask.

Office Hours: Hours are by appointment. Appointments are available Monday through Thursday. Urgent appointments are available. We do not have an answering service. Voicemail is provided for your convenience; you may leave a message for a return call. If you have an after-hours emergency, please call 911 or go to the nearest emergency room.

Co-pays, Deductibles, and Billing: All co-pays and deductibles are due at the time of service. We also accept major credit cards.

Office Procedures: Our office utilizes government certified electronic medical record software. Most of our charting is done in the exam room. The appointment time you are given allows for 15 minutes of charting before you see the doctor.
Please limit your initial visit to one primary complaint to receive the most efficient and comprehensive care. We look forward to getting to know you and helping you improve and maintain your health

Please present your insurance card(s) to the front desk.

1. Demographic information

Patient Name:

Sex:
○ M ○ F

D.O.B:

Cell Phone: (write none if no cell phone)

Home Phone:

Primary Address

City:

State:

Zip:

Email address (none if no email)

Marital Status:
○ Married ○ Single ○ Widowed ○ Divorced

Race:
○ White ○ Black ○ American Indian ○ Asian
○ Pacific Islander ○ Other

Ethnicity:
○ Hispanic ○ Non- Hispanic

How would you like to receive appointment reminders?
○ Phone Call ○ Text ○ Email

Primary Language

All languages spoken

How did you hear about us?

Occupation

Primary Insurance: (Self Insured: None)

Policy ID #:

Secondary Insurance:

Policy ID #:

Insured's name:

Insured's Date of Birth

Emergency Contact

Emergency Contact's Phone number

Emergency Contact Relationship
☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ POA
☐ Friend

Did your primary provider refer you to this office?
○ Yes ○ No

Primary Provider (none if no primary)

Primary phone number (none if no primary)

Pharmacy Name (local pharmacy)

Pharmacy address

I agree that all the medical and personal information provided is accurate to the best of my knowledge.

Signature

Date

2. Medical Questions

Height (feet/inches): _____

Weight (lbs): _____

Last Primary Visit: (none if no primary) _____

Are you a diabetic?
○ Yes ○ No

How long have you been a diabetic? _____

What type of diabetes do you have?
○ Type I ○ Type 2

Which treatment method is used?
○ Oral Medication ○ Insulin ○ Diet Control

Name of MD treating your Diabetes? _____

Most recent blood sugar: _____

Most recent A1C: _____

How often do you take your blood sugar? _____

3. Were you treated for any falls in the last year?

☐ Yes ☐ No

_____ _____

Please describe your injury and treatment provided

_____

4. Do you have a local Vascular Surgeon?

○ Yes ○ No

Vascular Surgeon's Name

_____

5. Social History

Do you smoke? (cigarettes, vaping)
○ Yes ○ No

If Yes, how often?
○ Multiple a day
○ Once a day
○ Every other day
○ On occasion

How long have you been smoking?
○ less than 5 years
○ 5-10 years
○ 11-20 years
○ 20-40 years
○ 50 or greater years

Did you used to smoke?
○ Yes ○ No

Do you drink alcohol?
○ Yes ○ No

If Yes, Amount:
○ Daily ○ Weekly
○ Occasionally
○ Socially

6. What is your complaint?

_____

_____

_____

_____

7. Where is your pain/problem located specifically?

	Ankle	Heel	Arch	Top of Foot	Bottom of Foot	Ball of Foot	Between Toes	Toenails
Right Foot								
Left Foot								

8. How long have you had this complaint/condition?

_____

9. Did the problem result from a specific injury?

○ No ○ Yes

If yes, please describe

_____

10. Please rate your pain on a scale of 1-10 (with 10 being the most painful)

	Your pain from 1 to 10
At rest	
At its worst	

11. What kind of pain is it?

	Constant	Occasional	Sharp	Dull	Aching	Stabbing	Throbbing	Radiating/Traveling
The pain is...								

Other

_____

12. What symptoms are you experiencing?

	Locking	Numbness	Giving Away	Popping	Tingling	Burning	Grinding	Swelling	Bruising
I have...									

Other

_____

13. Does anything make your symptoms feel better or worse?

_____

_____

_____

_____

14. Have you seen another physician for this problem?

○ No ○ Yes

Physician's name

_____

15. What treatments have you tried?

	Nothing	Physical Therapy	Injections	Bracing	Icing	Compression	Medications	Shoe Change	Arch Support	Massage
Have Tried										

Other

_____

16. Have you had any of the following test/studies for this condition/complaint?

	X-Rays	Blood Test	MRI	CT Scan
Tests				

If so, where were the test preformed?

_____

17. Please list all current medications or provide a medication list.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

18. Please list allergies including medication, tape, and latex allergies.

	Allergies
1	
2	
3	
4	
5	

19. Please choose all of your current and past medical history.

- ☐ I DO NOT HAVE ANY MEDICAL PROBLEMS
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTIFICAL CARDIAC VALVES
- ☐ ASTHMA / BRONCHITIS
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ BPH (ENLARGED PROSTATE)
- ☐ CANCER
- ☐ CARDIAC VALVE DISEASE
- ☐ CONGESTIVE HEART FAILURE
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DIABETES TYPE 1
- ☐ DIABETES TYPE 2
- ☐ EMPHYSEMA
- ☐ ENDOMETRIOSIS
- ☐ EPILEPSY
- ☐ GASTROINTESTINAL ISSUES
- ☐ GERD (REFLUX)
- ☐ GOUT / ELEVATED URIC ACID
- ☐ HEPATITIS A
- ☐ HEPATITIS B / C
- ☐ HERNIATED DISC
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIP REPLACEMENT
- ☐ HIV/ AIDS
- ☐ HYPOTHYROIDISM
- ☐ IRREGULAR HEART BEAT
- ☐ KNEE REPLACEMENT
- ☐ LIVER DISEASE
- ☐ LUPUS
- ☐ LYMPHEDEMA
- ☐ KIDNEY DISEASE
- ☐ MIGRAINES
- ☐ NEUROPATHY
- ☐ NEUROMUSLCAR DISEASE
- ☐ OSTEOPENIA/OSTEPOROSIS
- ☐ OSTEOARTHRITIS
- ☐ OVERACTIVE BLADDER
- ☐ OXYGEN DEPENDENT
- ☐ PACEMAKER
- ☐ PARKINSON'S DISEASE
- ☐ PCOS (POLYCYSTIC OVARIES)
- ☐ PERIPHERAL ARTERIAL DISEASE
- ☐ POOR CIRCULATION
- ☐ PTSD
- ☐ RHEUMATOID ARTHRITIS
- ☐ STROKE
- ☐ SWELLING IN LEGS
- ☐ ULCERS / WOUNDS
- ☐ OTHER
- ☐ OTHER

Taub Podiatry Financial Policy

Patient's Name: DOB:

Printed Name of Person Signing Form: Relationship to Patient:

Patients, or Legal Guardians of patients under the age of eighteen, must sign and date below before medical care can be rendered.

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- 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.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/coinsurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 an 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.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- 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.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

By signing I agree that I have read, understood and agree with Taub Podiatry's Financial Policy.

Client Signature Date