WELCOME TO NORTHEAST IOWA PODIATRY, P.C.

First Name: ____________________________MI: _____Last Name: ________________________

Gender: Male ___ Female ____ SSN: ____- ____-____ Birthdate: ____/____/____

Street Address: ____

City: _________________________________ State: ______ Zip Code: ___________

Home Phone: _______________ Work Phone: ______________ Cell Phone: _____________

E-mail: ______________________Best Time To Reach You? _____________________________

Marital Status: S M W D Are you a student?: yes no Are you employed ?: yes no

Place of Employment: ____

Race ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Asian
☐ Native Hawaiian / Other Pacific Islander ☐ Not Specified

Ethnicity ☐ Not Hispanic / Latino ☐ Hispanic / Latino

Emergency Contact (Name and Phone): ____

Primary Care Physician: _____________________________ Date Last Seen: ____/____/____

Referring Doctor: ___________________________________

Primary Insurance:

____

Required if different than patient

Insured Name: ________________________

Relationship to Patient: _________________

Date of Birth: ____/____/_____

Policy Number: ________________________

Group Number: _______________________

Secondary Insurance:

____

Required if different than patient

Insured Name: ____________________________

Relationship to Patient: _____________________

Date of Birth: ____/____/____

Policy Number: ___________________________

Group Number: __________________________

Patients Name : ______________________________

MEDICAL AND PODIATRIC HISTORY

My foot problem is: ____

Is this due to an injury? __________ If yes, is it work related? ____________ Date of Injury ______________________

Right Foot Left Foot Both Feet

It has troubled me for: ________ weeks ____________ months ___________ years

Are you allergic to any of the following?:

_______	Adhesive/Tape	_______	Aspirin	_______	Codeine
_______	Demerol	_______	Iodine	_______	Novocain
_______	Penicillin	_______	Seafood	_______	Sulfa

Others: _____________ _____________ _____________

Do you have a family history of any of the following?:

_______ Arthritis _______ Diabetes _______ Foot Problems Other: ___________________

List current medications being taken: ____

____

Have you ever been treated for any of the following?:

_______	AIDS/HIV	_______	Epilepsy	_______	Psychiatric Problems
_______	Anemia	_______	Glaucoma	_______	Rheumatic Fever
_______	Artificial Heart Valves	_______	Gout	_______	Stomach Problems
_______	Asthma	_______	Heart Problems	_______	Stroke
_______	Back Problems	_______	High Blood Pressure	_______	Other:______________
_______	Bleeding Tendencies	_______	Kidney/Bladder Problems	_______	___________________
_______	Cancer	_______	Liver Problems	_______	___________________
_______	Diabetes	_______	Neuromuscular Diseases	_______	___________________

List surgical operations: ____

____

Are You a smoker?: yes no

Your Pharmacy Name: ________________________________ **Location:** ______________________

ASSIGNMENT AND RELEASE

- I hereby give Dr. Stephen Solomon, Dr. Kelsey Harvey and associates permission to diagnose and treat my foot condition.
- I also authorize this office to release medical information to insurance carriers necessary in securing payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for giving "Northeast Iowa Podiatry, PC" the correct insurance information at the time services are rendered. Northeast Iowa Podiatry, PC agrees to bill your insurance carrier(s). All insurance information must be provided to our office, at the time of service.
- I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.
- I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion). I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties.
- I understand that Northeast Iowa Podiatry, PC is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

____ _____________________________
Signature of Responsible Party Date

Name of Responsible Party (If different from the patient) ____

Address (If different from patient) ____

Acknowledgement of Receipt of Notice of Privacy Practices

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

____ _____________________________
Patient Name (please print) Date

____
Parent of Authorized Representative (if applicable)

____
Signature

Medicare Part B Signature Authorization

____
Patient Name (please print)

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION.

____
Signature