Sims & Associates Podiatry

**POUGHKEEPSIE**
5 Eastdale Avenue South
Poughkeepsie, NY 12603
**845.471.2243**

**FISHKILL**
969 Main Street
Fishkill, NY 12524
**845.897.2735**

**HIGHLAND**
60 Park Lane
Highland, NY 12528
**845.834.3880**

# Patient Information & Medical History

**Today's Date**:

**Name**: _____ **DOB**: ___/___/_____ **Chart Number**: _____

**Sex**: ☐M ☐F **Marital Status**: ☐Single ☐Married ☐Divorced ☐Widowed **SSN**: _____/_____/_____

**Email**: _____ **Spouse/Partner Name**: _____

**Emergency Contact Name**: _____ **Phone**: _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Home Phone**: _____ **Cell Phone**: _____ **Other Phone**: _____

**Employer**: _____ **Phone**: _____

**Employer Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Primary Insurance**: _____ **Are you the insured?:** ☐Y ☐N

**Insured Information**
**Subscriber Name**: _____ Relationship to Insured: ☐Spouse ☐Child ☐Self ☐Other

**Phone**: _____ **Sex**: ☐M ☐F **DOB**: ____/____/_____

**Address**: _____

**Policy ID**: _____ **Group ID**: _____ **Employer**: _____

**Secondary Insurance**: _____ **Are you the insured?:** ☐Y ☐N

**Insured Information**
**Subscriber Name**: _____ Relationship to Insured: ☐Spouse ☐Child ☐Self ☐Other

**Phone**: _____ **Sex**: ☐M ☐F **DOB**: ____/____/_____

**Address**: _____

**Policy ID**: _____ **Group ID**: _____ **Employer**: _____

**How did you find out about our practice?** ☐Physician ☐Internet ☐Social Media ☐Family Member ☐Friend ☐Other: _____

**What is the reason for your visit today?** _____
_____ **Result of an accident or work injury?** ☐Y ☐N

**How long has this bothered you?** 1 2 3 4 5 6 7 ☐Days ☐Weeks ☐Months ☐Years

**What treatments have you tried and have they been effective?**_____
_____

**On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain?** _____/10

**The pain quality is:** ☐Burning ☐Constant ☐Dull ☐Sharp ☐Shooting ☐Throbbing ☐Tingling ☐Other: _____

**PLEASE READ AND SIGN**
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

## History & Physical

**Name**: _____ **DOB**: ___/___/___ **Chart Number**: _____

**Medical History**

| | | | | | |
|---|---|---|---|---|---|
| ☐Alcoholism | ☐Blood Disorder | ☐Circulation Problems | ☐Musculoskeletal | ☐Breathing Issues | |
| ☐Liver | ☐Sleep Apnea | ☐Gout | ☐Allergies | ☐Heart Disease | ☐Asthma |
| ☐Heart Murmur | ☐Stomach/Bowel | ☐Depression | ☐Anxiety Disorder | ☐Mental Illness | ☐Kidney Disease |
| ☐Blood Clot | ☐High Cholesterol | | ☐High Blood Pressure | ☐Cancer | ☐Hepatitis |
| ☐Neuropathy (specify)_____ | | ☐Thyroid (specify)_____ | | ☐Diabetes Type 1, Type 2 | |
| ☐Arthritis (specify)_____ | | ☐Other (specify)_____ | | ☐HIV | ☐CVA |
| Are You Pregnant? ☐Y ☐N ☐N/A | | Are You Nursing? ☐Y ☐N ☐N/A | | ☐Skin Cancer | ☐Stroke |

**Surgical History** ☐None ☐Appendectomy ☐C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐Y ☐N
If yes, please describe: _____
Any artificial joints? ☐Y ☐N If yes, where: _____ Do you have an artificial heart valve? ☐Y ☐N

**Social History**
Do you smoke? ☐Y ☐N If yes, how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long? _____
Do you drink alcohol? ☐Yes, everyday (5-7 days/) ☐Yes, occasionally/socially ☐No/rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐No, I have never had a substance abuse problem.
What is your occupation? _____ Does it involve mostly: ☐Standing or ☐Sitting
Do you exercise regularly? ☐No, I do not exercise regularly. ☐Yes, I do the following regular exercise: _____
_____

**Family History**
**Is there any family history** *(blood relative)* **of:** *(please specify family member)*

| | | | |
|---|---|---|---|
| ☐Alzheimer's | _____ | ☐Depression | _____ |
| ☐Arthritis | _____ | ☐Diabetes | _____ |
| ☐Bleeding Disorders | _____ | ☐Emphysema | _____ |
| ☐Blood Clots | _____ | ☐Heart Disease | _____ |
| ☐Cancer | _____ | ☐High Blood Pressure | _____ |
| ☐Cataracts | _____ | ☐Neurological | _____ |
| ☐Circulation Problems | _____ | ☐Stroke | _____ |

**Review of Symptoms** *(Please check the box if you currently have any of these symptoms or check 'NONE')*

| | | | | | | |
|---|---|---|---|---|---|---|
| **Cardiovascular** | ☐Leg pain when walking | ☐Fever | ☐Chest pain/pressure | ☐Leg swelling | ☐Cold hands/feet | |
| | ☐Fainting | ☐Palpitations | ☐Vascular disease | ☐Valve problems | ☐None | |
| **Genitourinary** | ☐Blood in urine | ☐Hesitancy | ☐Incontinence | ☐Increased urgency | | |
| | ☐Decreased frequency | ☐Excessive urination | ☐Kidney disease | ☐Kidney stones | ☐None | |
| **Gastrointestinal** | ☐Abdominal pain | ☐Heart burn | ☐Blood in stool | ☐Vomiting | ☐Ulcers | ☐Constipation |
| | ☐Diarrhea | ☐Trouble swallowing | ☐Decreased appetite | ☐Increased appetite | ☐None | |
| **Integumentary** | ☐Athletes foot | ☐Nail abnormalities | ☐Keloids | ☐Itchiness | ☐Dry, scaly skin | ☐None |
| **Hematologic** | ☐Lower leg ulcers | ☐Sickle cell disease | ☐Anemia | ☐Blood thinners | ☐Clotting disorders | ☐None |
| **Neurological** | ☐Tingling | ☐Weakness | ☐Seizures | ☐Headache | | |
| | ☐Tremors | ☐Paralysis | ☐Numbness | ☐None | | |
| **Musculoskeletal** | ☐Back pain | ☐Joint swelling | ☐Muscle weakness | ☐Muscle pain | ☐Arthritis | |
| | ☐Sciatica | ☐Joint stiffness | ☐Joint pain | ☐Joint instability | ☐Neck pain | ☐None |
| **Respiratory** | ☐Chest pain | ☐Wheezing | ☐COPD | ☐Snoring | | |
| | ☐Shortness of breath | ☐Emphysema | ☐Coughing | ☐None | | |

**PLEASE READ AND SIGN**
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

**Sims & Associates Podiatry**

**Name**: _____ **DOB**: ___/___/___ **Chart Number**: _____

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

**Race:** ☐ Asian ☐ Native American or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Decline to specify

Preferred Language:_____ ☐ Decline to specify

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Address:_____ City, State, Zip:_____

Primary Care Physician:_____ Phone: _____ Date Last Seen:_____

Address:_____

Referring Physician:_____ Phone: _____ Date Last Seen:_____

Address:_____

**Privacy Information Preferences**

Do you want to be exempt from public reporting? ☐Y ☐N Can we send mail to the address on file? ☐Y ☐N

Can we call the phone number on file? ☐Y ☐N Can we leave a voice message on machine? ☐Y ☐N

Will you allow us to send internet based (email) delivery of appointment reminders and newsletters? ☐Y ☐N

If so, please provide your email address:_____

Who can we leave messages with? ☐Spouse ☐Children ☐Other: _____

Name(s): _____

**Smoking Status**

☐Smoker, Current Every Day ☐Smoker, Current Status Unknown

☐Smoker, Current Some Days ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

**Vital Signs**

Blood Pressure: _____ / _____

Height:_____ Weight:_____

**Current Medications**

☐ No Known Medications ☐ I take the following medications:

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

Use the back of this form if more room is needed

**Allergies**

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

Use the back of this form if more room is needed

**Last Flu Shot Date:** _____ **Did you get a pneumococcal vaccination?** ☐Y ☐N

**Have you fallen in the last 12 months?** ☐Y ☐N **Were you injured from the fall**? ☐Y ☐N

**Advanced Directives:** ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

**PLEASE READ AND SIGN**

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

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# Insurance Authorization & Assignment Form

All professional services rendered are charged to the patient. The necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of any insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance with our office.

If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

I hereby authorize Lewis J. Sims, DPM, PC to furnish any information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I UNDERSTAND THAT IF MY INSURANCE REQUIRES A REFERRAL, AND I DO NOT HAVE ONE, I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.

| Insured Name (please print) | Signature | Date |
|---|---|---|
| Patient Name (please print) | Signature | Date |

# 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 understood the notice.

_____ _____

Patient Signature Date

_____

Parent of Authorized Representative (if Applicable)

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# Patient Financial Policy

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, payments 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/co-insurance/deductible at the time of service.
- 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.
- You must inform the office of all insurance charges 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 them. In the event that it is, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All cost 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 $25.00 for all returned checks. Your insurance company does not cover this fee.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Responsible Party | Print Name of Patient/Responsible Party | Date |
| _____ | _____ | _____ |
| Signature of Witness | Print Name of Witness | Date |

_____ Patient initials to indicate copy received