Brett Chicko, DPM

Foot and Ankle Specialist

www.brettchickodpm.com

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Patient Information

Date_____

Name_____
Last First Middle Initial

Address_____
Number Street Apt

_____
City State Zip

Required—Please answer question below

Home Phone: _____ Work Phone: _____

Cell Phone: _____ OK to receive Text? Yes / No

Email: _____

Your Pharmacy Name/Address:_____
Name, Address or Phone Number

Date of Birth: _____ SS#: _____-_____-_____

Emergency Contact: Name _____ **Relationship** _____

Home Phone _____ Cell Phone _____

Primary Care Physician _____

Marital Status _____Divorced_____Married_____Partner_____Single_____Widowed_____Legally Separated_____

Social Information: It is a federal requirement that we ask the next questions. If you are uncomfortable answering any of these, you have the option to decline by leaving it blank.

Primary Language: _____

Race (Please Circle): American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Ethnicity (Please Circle): Hispanic/Latino or Not Hispanic/Latino

Gender Identity (Please Circle): Male / Female / Transgender Male: Female-to-Male (FTM) / Transgender Female: Male-to-Female (MTF) / Gender non-conforming (neither exclusively male nor female) / Additional gender category; other, please specify_____ / Choose not to disclose

Have you seen Dr. Chicko at one of his past practices? Yes / No

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What is the REASON FOR YOUR VISIT today? PLEASE LIMIT 1-2 Reasons Per Appointment:

1._____

2._____

When did your symptoms start? _____

Please list all **MEDICATIONS** you are currently taking including STRENGTH

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL PROBLEMS

What **medical problems** do **you** have or **are you being treated** for? Please circle all that apply:

AIDS/HIV
Anemia
Arthritis
Artificial joints
Asthma
Back Pain
Bleeding disorder
Blood Clot
Cancer
Coronary Artery Disease
Deep Vein Thrombosis
Diabetes
Dialysis
Dyslipidemia
Edema
Fibromyalgia
Foot Deformity
Frost Bite
Gout
Headaches
Heart Disease
Hepatitis
Hernia
Hypertension
Kidney Disease
Leg or Foot Ulcers
Liver Disease
Lung Disease
Organ Transplant
Osteoporosis
Pacemaker
Peripheral Vascular Disease
Polio
Pulmonary Embolism
Raynaud's Disease
Rheumatoid Arthritis
Seizures/Epilepsy
Stroke
Substance Abuse
Thyroid Problems
Tuberculosis
Varicose Veins

Other Medical History: _____

Please list any **ALLERGIES** to **MEDICATIONS**:

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

Please list any **surgeries/operations** you have had:

_____
_____

FAMILY HISTORY

(Please **√** and state which family member i.e.: father, mother, brother sister, ***maternal or paternal*** grandmother/grandfather, ***maternal or paternal*** aunt/uncle, etc.)

Alzheimer's _____
Anemia _____
Arthritis _____
Asthma _____
Cerebral Vascular Accident _____
Chronic Obstructive Pulmonary Disease _____
Coronary Arteriosclerosis _____
Deformity of Foot _____
Dementia _____
Diabetes Mellitus _____
Disorder of Thyroid _____
Epilepsy _____
Gout _____
Heart Disease _____
Hypertensive Disorder _____
Hypocholesteremia _____
Liver Problem _____
Malignant Neoplastic Disease _____
Osteoporosis _____
Rheumatoid Arthritis _____
Seizure _____

SOCIAL HISTORY

Smoking Status (Please Circle):
Current every day smoker / Current some day smoker / Former Smoker/ Never Smoked

If current smoker, some day smoker, or former smoker:
How many years have you been smoking? _____ How much do you smoke? _____
Former Smoker: When did you quit? _____ How many years did you smoke? _____

Alcohol Use (Please Circle): None-do not drink / Occasional Drinker / Social Drinker / Heavy Drinker

Recreational Drugs: _____

Marital Status (Please Circle): Single / Married / Separated / Domestic Partner / Divorced / Widow

Primary Care Doctor: _____
Name of Person or Practice

How did you hear about us (Please Circle): Primary Care Doctor Insurance Company Friend/Family
Internet (choose one): Google Yahoo ZocDoc Our Website
Other (please specify): _____

****** An office visit is not a guarantee of surgery. Patient must meet certain requirements/criteria at the discretion of Dr. Chicko before being able to schedule surgery.******

Do you frequently experience or have you recently experienced any of the following symptoms? PLEASE CIRCLE:

Constitutional: Overall Health _____			Change in Appetite	Fatigue
	Fever	Headache	Weight Gain	Weight Loss
Allergy/Immunology:		Cough	Watery Eyes	Wheezing
ENT:	Blocked Ear	Dry Mouth	Ear Pain	Sore Throat
Endocrine:	Dizziness	Excessive Thirst	Frequent Urination	Weakness
Respiratory:	Chest Pain	Cough	Shortness of Breath	Wheezing
Cardiovascular:	Chest Pain	Chest Pain with exertion	Dizziness	Irregular Heartbeat
Genitourinary:	Abdominal Pain	Blood in Urine	Painful Urination	Frequent Urination
Musculoskeletal:	Back Problems	Joint Swelling	Muscle Aches	Swollen Joints
Peripheral Vascular:		Cold Extremities	Decreased Sensation in Extremities	
Skin:	Discoloration	Dry Skin	Itching	Rash
Neurologic:	Balance Difficulty	Loss of Strength	Tingling/Numbness	Tremor
Psychiatric:	Anxiety	Depressed Mood	Loss of Appetite	Substance Abuse

Height: _____ Weight: _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Chicko to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles and/or legs.

Signature: _____

Printed Name: _____ Date: _____/_____/_____

Please fill out back page

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Financially Responsible Person

Name_____ Relation to Patient:_____

Phone:_____

Address: _____Email: _____

Employer Name/Address _____

Other Persons to Notify in Emergency: _____ Phone: _____

Medical Insurance Coverage

(If you provide the staff with your Health Insurance Card(s), you do not have to fill out the information below)

Name of Primary Insurance _____

ID/Policy #_____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Holder: Self ____ Spouse: _____ Guardian: _____

Name of Secondary Insurance: _____

ID/Policy # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Holder: Self: _____ Spouse: _____Guardian: _____

I understand and acknowledge that I am personally responsible for the services rendered at this facility. Brett Chicko, DPM Foot and Ankle Specialist will bill my insurance as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

_____ _____

Signature of Subscriber or beneficiary **Date**

Brett Chicko, DPM

Foot and Ankle Specialist

Financial Policy

PLEASE NOTE: IT IS YOUR RESPONSIBILITY FOR ANY FINANCIAL OBLIGATIONS EVEN IF YOU DO NOT SIGN THIS FORM. IF YOU RECEIVE TREATMENT, THESE POLICIES WILL BE STRICTLY ENFORCED.

NEW INSURANCE: Please notify us immediately if your insurance has changed. We will make a copy of the front and back of your insurance card at your New Patient visit. Please inform us of any changes in your health insurance coverage.

COPAYMENT: All copayments are due at the time of your appointment. Your copay amount is the amount that you agreed upon with your Insurance Company when you signed up for your Health Insurance Plan. Your copay is collected at each doctor's visit and may change from year to year. It is your responsibility to notify us of any changes. *If your Health Insurance Company does not provide us with your copay amount at the time of your visit, you will still be held responsible to pay that amount to our practice once your claim has been processed.*

DEDUCTIBLE: The amount you pay for covered health care services before your insurance plan starts to pay. After you have met your deductible, you will then usually pay only a copayment or coinsurance for covered services.

DIVORCED OR SEPARATED PARENTS: Any copay due at the time of service or balances left after insurance will be *the responsibility of the parent or guardian bringing the child for treatment*. The physician and medical staff do not get involved with the financial arrangement between the parents.

REFERRALS: If your insurance plan requires a Referral from your Primary Care Physician (PCP), then you are responsible for obtaining a referral prior to your visit with our practice. If you fail to obtain a referral, then you will be responsible for full payment of medical services rendered.

COMPLETION OF FORMS: All forms to be completed by medical staff members (i.e. Workers Compensation, FMLA, Disability, etc.) will be subject to a **$25** charge that will be paid prior to the time in which the form is completed and received. There is no charge for a form that is completed during an office visit.

NO SHOW FEE: If you missed the scheduled appointment without notifying our office, a **$25** charge will be added to your account.

RETURNING CHECK FEE: $50.00 charge for all returned checks

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Brett Chicko, DPM Foot and Ankle Specialist all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment or benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, any third party as it materially relates to services provided, or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: _____

Printed Name: _____ Date: _____/_____/_____

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Notice of Privacy Practices

(Please see Notice of Privacy Practices located on our website at: www.brettchickodpm.com under the Tab "Patient Resources". If you are unable to locate the Notice of Privacy Practice, please ask a staff member for a copy).

Right to Refuse Treatment:

You must notify a staff member if you are a Registered Sex Offender.

Family Foot and Ankle Center, LLC dba Brett Chicko, DPM Foot and Ankle Specialist, has the right to refuse treatment for any reason deemed necessary by the practice.

I acknowledge that I have read, understand and approve the above referenced document.

Signature: _____

Printed Name: _____ Date: _____/_____/_____