Bruce B. Levin DPM PA

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Phone (623) 977-9100 Fax (623) 977-8020

## PATIENT INFORMATION

DATE: _____

NAME: _____

BIRTH DATE: _____ AGE: _____ PHONE: _____ CELL PHONE:

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

EMAIL ADDRESS: _____

OUT OF STATE ADDRESS: _____

EMPLOYER NAME: _____ WORK PHONE: _____

EMPLOYEE ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

SOCIAL SECURITY #: _____

HOW DID YOU LEARN ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN: _____

## EMERGENCY CONTACT

(To be notified in case of emergency. Someone NOT living with you).

NAME: _____HOME PHONE: _____

RELATIONSHIP: _____WORK PHONE: _____

HOME ADDRESS: _____

EMPLOYER: _____

## RESPONSIBLE PARTY INFORMATION

(Person responsible for paying any balance not covered by insurance).

NAME: _____HOME PHONE: _____

RELATIONSHIP:_____DOB: _____SSN #: _____

ADDRESS:_____

HOME PHONE: _____WORK PHONE: _____

# INSURANCE INFORMATION

## PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY NUMBER: _____GROUP NUMBER:_____

INSURANCE PHONE NUMBER: _____EFFECTIVE DATE: _____

NAME OF INSURED PERSON: _____

CO-INSURANCE PERCENTAGE OR CO-PAY AMOUNT: _____

ANNUAL DEDUCTIBLE: _____

## SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY NUMBER: _____GROUP NUMBER:_____

INSURANCE PHONE NUMBER: _____EFFECTIVE DATE: _____

NAME OF INSURED PERSON: _____

## RELEASE OF INFORMATION/INSURANCE ASSIGNMENT

| DO WE HAVE PERMISSION TO? | YES | NO |
|---|---|---|
| LEAVE A MESSAGE ON YOUR HOME ANSWERING MACHINE? | ☐ | ☐ |
| LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? | ☐ | ☐ |
| DISCUSS YOUR MEDICAL CONDITION WITH ANY FAMILY MEMBERS? | ☐ | ☐ |
| IF YES, WITH WHOM? | ☐ | ☐ |

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES I HAVE BEEN PROVIDED. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AUTHORIZE BRUCE B. LEVIN DPM PA TO APPLY FOR BENEFITS ON MY BEHALF FOR ANY COVERED SERVICES. I REQUEST THAT PAYMENT FROM THE INSURANCE COMPANY BE MADE DIRECTLY TO BRUCE B. LEVIN DPM PA. I AUTHORIZE BRUCE B. LEVIN DPM PA TO CONTACT AND FORWARD ANY PERTINENT MEDICAL INFORMATION TO MY OTHER PHYSICIAN FOR THEIR RECORDS. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE COMPANY.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

**PATIENT SIGNATURE: _____**

**DATE: _____**

## SOCIAL HISTORY

| | YES? | NO? |
|---|---|---|
| DO YOU SMOKE? | ☐ | ☐ |
| DO YOU DRINK? | ☐ | ☐ |

IF YES, NUMBER OF PACKS PER DAY? _____

IF YES, NUMBER OF OUNCES YOU DRINK PER WEEK? _____

DOES YOUR WORK OR LIFESTYLE INVOLVE SPENDING LARGE AMOUNTS OF TIME ON YOUR FEET? _____

IF YES, PLEASE EXPLAIN: _____

OCCUPATION: _____

DO YOU EXERCISE? _____ IF YES, HOW MUCH AND HOW OFTEN? _____

## FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

| | YES? | NO? |
|---|---|---|
| DIABETES | ☐ | ☐ |
| HEART DISEASE | ☐ | ☐ |
| BLOOD CLOTS | ☐ | ☐ |
| BLEEDING PROBLEMS | ☐ | ☐ |
| STROKE | ☐ | ☐ |
| GOUT | ☐ | ☐ |
| RHEUMATOID ARTHRITIS | ☐ | ☐ |

## MEDICATIONS

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) THAT YOU TAKE ON A REGULAR BASIS AND WHY.

| MEDICATION | MILLIGRAMS | HOW OFTEN | WHY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| PENICILLIN | ☐ | ☐ | CODEINE | ☐ | ☐ |
| ASPIRIN | ☐ | ☐ | OTHER | ☐ | ☐ |
| IODINE | ☐ | ☐ | | | |
| SULFA | ☐ | ☐ | | | |
| ADHESIVE TAPE | ☐ | ☐ | | | |
| NOVOCAIN | ☐ | ☐ | | | |
| SHELLFISH | ☐ | ☐ | | | |
| LATEX | ☐ | ☐ | | | |

## PATIENT MEDICAL HISTORY

LOCAL PHYSICIAN: _____LAST VISIT: _____

OTHER PHYSICIAN:_____LAST VISIT: _____

FORMER PODIATRIST: _____PHONE #: _____

LAST VISIT: _____

HEIGHT:_____WEIGHT:_____ SHOE SIZE:_____

WHAT TYPE OF FOOT PROBLEMS BRING YOU TO OUR OFFICE?

_____

## PAST MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| DIABETES | ☐ | ☐ | COPD/EMPHYSEMA | ☐ | ☐ |
| ABNORMAL HEART CONDITITON | ☐ | ☐ | ASTHMA | ☐ | ☐ |
| HEART ATTACK | ☐ | ☐ | STROKE | ☐ | ☐ |
| MITRAL VALVE PROLAPSE | ☐ | ☐ | SEIZURES OR EPILEPSY | ☐ | ☐ |
| VASCULAR DISEASE/BAD CIRCULATION TO FEET | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ |
| ABNORMAL BLOOD PRESSURE | ☐ | ☐ | LIVER DISEASE | ☐ | ☐ |
| LUNG DISEASE | ☐ | ☐ | HEPATITUS | ☐ | ☐ |
| STOMACH ULCERS | ☐ | ☐ | THYROID DISEASE | ☐ | ☐ |
| ARTHRITIS/OSTEOARTHRITIS | ☐ | ☐ | RHEUMATOID ARTHRITIS | ☐ | ☐ |
| GOUT | ☐ | ☐ | NEUROPATHY/NUMBNESS | ☐ | ☐ |
| ARTIFICIAL JOINTS | ☐ | ☐ | DIFFICULTY IN HEALING | ☐ | ☐ |
| CANCER | ☐ | ☐ | HIV | ☐ | ☐ |
| OTHER: | | | | | |

PLEASE DESCRIBE ANY OTHER MEDICAL PROBLEMS INCLUDING FOOT PROBLEMS THAT YOU HAVE ENCOUNTERED.

_____

_____.

FOR WOMEN ONLY: ARE YOU PREGNANT? _____IF SO, HOW MANY MONTHS? _____LMP: _____

## PAST SURGICAL HISTORY AND HOSPITALIZATIONS

PLEASE GIVE ANY DETAILS OF ANY:

| OPERATIONS/SERIOUS INJURIES | APPROXIMATE DATE WHEN OCCURRED | PHYSICIAN | HOSPITAL |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE PLACE A CHECK NEXT TO ANY PROBLEMS YOU MAY BE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

**CONSTITUTIONAL**

☐ Decrease in Appetite ☐ Faintness ☐ Fever

☐ Headache ☐ Feeling Room Spinning ☐ Weakness

☐ Weight Loss ☐ Weight Gain ☐ None

COMMENTS: _____

**SKIN/NAILS**

☐ Allergic to Chemicals ☐ Skin Dryness ☐ Thick or Discolored Toenails

☐ Skin Itching ☐ Skin Cracking ☐ Thick or Discolored Finger Nails

☐ Skin Cancer ☐ Scarring After Surgery/Injury ☐ None

COMMENTS: _____

**MUSCULOSKETAL**

☐ Joint Aches or Paints ☐ Chronic Neck Pain ☐ Chronic Hip or Knee Pain

☐ Chronic Lower Back Pain ☐ Chronic Ankle Pain ☐ Stiffness

☐ Swelling in Joints ☐ Morning Sickness ☐ Pain Upon Rising in the Morning or at any time

☐ None

COMMENTS: _____

**CARDIOVASCULAR**

☐ Chest of Arm Pain ☐ Blood Clots ☐ Cramps in legs or feet when walking

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Cramps when sleeping in legs or feet

☐ Heart Attack ☐ Heart Murmur ☐ Heart Palpitations

☐ Stroke ☐ Varicose Veins ☐ Mitral Valve Prolapse ☐ None

COMMENTS: _____

**NEUROLOGIC**

☐ Tingling ☐ Pins and Needles ☐ Numbness

☐ Burning ☐ Increased Sensitivity to Touch ☐ Decrease or Lack of Sensation to Touch

☐ Shooting Paint ☐ Radiating Pain ☐ Decrease or Lack of Sensation in Cold or Warmth

☐ None

COMMENTS: _____

**ALLERGIC/IMMUNLOGIC**

☐ Lumps in Groin or Armpit ☐ Fever ☐ Chills
☐ Night Sweats ☐ Sore Throat ☐ Coughing
☐ Wheezing ☐ General Feeling of Being Sick ☐ None

COMMENTS: _____

**ENDOCRINE**

☐ Increase or Decrease in Thirst ☐ Increase of Decrease in Appetite ☐ Increase or Decrease in Urination
☐ Weight Loss or Gain ☐ Diabetes Mellitus ☐ Thyroid Problem
☐ Post Menopause ☐ Sensitivity to Heat or Cold ☐ None

COMMENTS: _____

**RESPIRATORY**

☐ Difficulty in Breathing ☐ Cough ☐ Coughing Blood
☐ Wheezing ☐ Shortness in Breath ☐ Difficulty in Breathing When Laying Flat
☐ Waking Up Short of Breath ☐ None

COMMENTS: _____

**EARS, NOSE, MOUTH, THROAT**

☐ Headache ☐ Convulsions ☐ Dentures
☐ Difficulty Hearing ☐ Nose Bleeds ☐ Sore Throat
☐ Migraines ☐ Dry Mouth ☐ Runny Nose
☐ Difficulty Swallowing ☐ Teeth of Gum Problems ☐ Ringing In the Ears
☐ Fainting Spells ☐ None

COMMENTS: _____

**EYES**

☐ Blurred Vision ☐ Double Vision ☐ Dry Eyes
☐ Eye Infections ☐ Runny or Draining Eyes ☐ None

COMMENTS: _____

**GASTROINTESTINAL**

☐ Abdominal Cramps ☐ Inflammation of Colon ☐ Constipation

☐ Diarrhea ☐ Heartburn ☐ Difficulty Swallowing

☐ Blood in Stool ☐ Hemorrhoids ☐ Jaundice or Yellow Skin

☐ Black or Tarry Stools ☐ Nausea ☐ Vomiting ☐ None

COMMENTS: _____

**GENITOURINARY**

☐ Inability to Urinate ☐ Pain or Urination ☐ Burning When Urinating

☐ Blood in Urine ☐ Dark Urine ☐ Excessive Number of Times Urinating at Night

☐ Inability to Hold Urine ☐ Yeast Infection ☐ Decrease in Amount of Urine Produced ☐ None

COMMENTS: _____

**PSYCHIATRIC**

☐ Dementia ☐ Depression ☐ Manic-Depression/Bipolar

☐ Memory Loss ☐ Confusion ☐ Panic Attacks

☐ Obsessive Compulsive Disorder ☐ Paranoia ☐ None

COMMENTS: _____

**HEMATOLOGICAL/BLOOD**

☐ Hemophilia ☐ Anemia ☐ Bruising Easily

☐ Blood Transfusion Reaction ☐ Sickle Cell Disease or Trait ☐ Leukemia

☐ Weakness ☐ Jaundice or Yellow Skin ☐ None

COMMENTS:_____

IS THERE ANYTHING YOU WISH TO TELL YOUR PHYSICIAN PRIVATELY? ☐ YES ☐ NO

WHICH PHARMACY DO YOU USE? _____

LOCATION? _____

PATIENT SIGNATURE AND DATE

_____

DPM REVIEWED, SIGN AND DATE_____

CHANGES NOTED AND DATED _____

## PRACTICE REQUIREMENTS

THIS PRACTICE:

*IS REQUIRED BY FEDERAL LAW TO MAINTAIN THE PRIVACY OF YOUR PRIVATE HEALTH INFORMATION (PHI) AND TO PROVIDE YOU WITH THIS PRIVACY NOTICE DETAILING THE PRACTICE'S LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PHI.

* UNDER THE PRIVACY RULE, MAY BE REQUIRED BY STATE LAW TO GRANT GREATER ACCESS OR MAINTAIN GREATER RESTRICTIONS ON THE USE OR RELEASE OF YOUR PHI THAN WHICH IS PROVIDED FOR UNDER FEDERAL LAW.

*IS REQUIRED TO ABIDE BY THE TERMS OF THE PRIVACY NOTICE.

*RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS PRIVACY NOTICE AND TO MAKE THE NEW PRIVACY NOTICE PROVISIONS EFFECTIVE FOR YOUR ENTIRE PHI THAT IT MAINTAINS.

*WILL DISTRIBUTE ANY REVISED PRIVACY NOTICE TO YOU PRIOR TO IMPLEMENTATION.

*WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

### EFFECTIVE DATE

*THIS NOTICE IS IN EFFECT AS OF 12/15/07.

## PATIENT ACKNOWLEDGEMENT

*BY SIGNING MY NAME BELOW, I ACKNOWLEDGE RECEIPT OF A COPY OF THIS NOTICE, AND MY UNDERSTANDING AND MY AGREEMENT TO ITS TERMS.

_____

PATIENT SIGNATURE

_____

DATE

# ARIZONA SPECIALTY FOOTCARE

## FINANCIAL POLICY

THANK YOU FOR CHOSING US AS YOUR HEALTH CARE PROVIDER. WE STRIVE TO PROVIDE THE MOST UP-TO-DATE AND COST EFFECTIVE TREATMENT, THERAPY, AND PRODUCTS FOR YOUR FOOT AND ANKLE CARE. PLEASE UNDERSTANDTHAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT.

MEDICARE PATIENTS ARE REQUIRED TO MEET A **$183.00** CALENDAR YEAR DEDUCTIBLE. IF YOU HAVE A SUPPLEMENTAL OR SECONDARY INSURANCE, PLEASE INFORM OUR STAFF PRIOR TO YOUR VISIT.

**NON-COVERED MEDICAL SUPPLIES OR SERVICES MUST BE PAID IN FULL AT THE TIME OF THE VISIT.**

INDEMNITY INSURANCE PLANS SUCH AS BLUE CROSS/BLUE SHIELD WILL BE BILLED. YOU WILL BE RESPONSIBLE FOR ANY CO-INSURANCE AND DEDUCTIBLE AMOUNTS. IF WE DO NOT RECEIVE PAYMENT WITHIN 90 DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS WHO ARE COVERED BY A COMMERCIAL INSURANCE CARRIER, WITH WHOM WE ARE NOT PRACTICING PHYSICIANS, WILL REMAIN REPSONSIBLE FOR THEIR BALANCE. WE WILL COURTESY BILL YOR CARRIER. IF WE DO NOT RECEIVE PAYMENT WITHIN **90** DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS THAT DO NOT HAVE MEDICAL INSURANCE WILL BE REQUIRED TO PAY FOR THEIR SERVICES RENDERED IN FULL ON THE DATE OF SERVICE. WE WILL TRY TO ACCOMMODATE PATIENTS BY SUPPLYING AN ESTIMATE PRIOR TO SEEING THE DOCTOR. PAYMENT PLANS ARE NOT ACCEPTED.

WE REQUIRE PAYMENT IN THE FORM OF CASH, MONEY ORDER, CHECK, OR VISA/MASTERCARD.

**CREDIT CARD GUARANTEE AUTHORIZATION IS RECOMMENDED.** PLEASE ASK THE RECEPTIONIST FOR FURTHER INFORMATION OR CONCERNS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINNCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

_____ _____

SIGNATURE OF WITNESS DATE

FOOTCARE SPECIALISTS OF ARIZONA

Bruce B. Levin D.P.M., F.A.C.F.A.S.

10503 W. Thunderbird Blvd., Suite 109

Sun City, AZ 85351

# Advance Beneficiary Notice (ABN)

## Patient agreement to pay for services not covered by insurance

## (Waiver of liability statement)

Name of patient:

Insurance pays only for services that are determined to be reasonable and necessary. If a particular service is not reasonable and necessary under insurance standards, although it would otherwise be covered, insurance denies payments for that service. I will be responsible for any balances that my insurance does not cover.

Patient signature _____

Witness signature _____

Date _____