

Personal Information

Today's date: _____

Patient's First Name: _____ MI: _____ Last Name: _____
Date of Birth: ____/____/____ Gender: Male / Female/ Other
Social Security #: _____ - _____ - _____ Marital Status: Married / Single / Divorced / Widowed
Race: White / Asian / African American / Hispanic / Latino / Pacific Islander / Native American
Ethnicity: Hispanic or Latino / Non-Hispanic or Latino
What is your preferred language? English / Spanish / Mandarin / Italian / Other: _____
Home Address: _____ City: _____ State: _____ Zip Code _____

Employment Information

You are currently: Employed / Unemployed / Student / Pre-school child / Retired
If you are employed, please provide the following information regarding your employer:
Employer Name: _____
Are you a member of a Union? Yes / No **If yes**, Local # _____

Personal communication and Emergency Contact Information

Home Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____
May we leave a message on your phone? Yes / No **If Yes**, Cell / Home / Work
May we send you an email, fax or text documents or messages? Yes / No
Email: _____ @ _____ . _____ Fax#: (____) _____ - _____
Emergency contact name: _____
Emergency contact phone #: (____) _____ - _____
Emergency contact relation: Spouse / Parent / Child / Friend / Sibling / Other _____

How were you referred to our office?

Medical Doctor / PT or Trainer/ Relative / Friend / Coworker / Google / Curalta Website / Insurance/
ZocDoc/Healthgrades/Social Media
Who may we thank for referring you?: _____

Are you here because of an Auto Accident or Workers Comp claim?

Is this visit due to an automobile accident: Yes / No

Is this visit due to a worker's compensation issue: Yes / No

If yes, please provide us with a copy of your insurance card, claim number and lawyer contact information

Insurance and Guarantor Information - *Please provide your insurance card or cards and photo ID*

Do you have health insurance: Yes / No, If yes, please continue below.

Name of Insurance Company: _____

Insurance ID #: _____

Are you the primary policy holder? Yes / No, If No please complete below

The primary policy holder is my: Spouse / Parent / Domestic Partner

If you are NOT the primary policy holder, please provide the following;

Primary policy holder's full name: _____

Primary policy holder's date of birth: ____/____/____

Primary policy holder's address: Same as mine: Yes / No

If No, please provide address: _____

Do you have a secondary insurance: Yes / No

Name of Insurance Company: _____

Insurance ID #: _____

If Yes, are you the secondary policyholder? Yes / No, If No, please complete below,

Secondary policy holders full name: _____

Secondary policy holder's date of birth: ____/____/____

Secondary policy holder's address: Same as mine: Yes / No

If No, please provide insured's address:

Primary Medical Doctor

Who is your Primary Medical Doctor? _____

Primary Doctor's Address: _____

What is their office phone number? (_____) _____ - _____

Do you see a specialist (endocrinologist, cardiologist, vascular surgeon)? _____

Dr Name: _____ Date of last visit: _____

Pharmacy Information

What **local** pharmacy do you use? _____

What street, town and state is your **local** pharmacy in? _____, _____, _____

May we electronically request your RX history from your pharmacy? Yes / No

By signing below, I authorize Curalta Foot & Ankle Associates (Curalta) to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Curalta, and it may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my Curalta medical record. I also give permission for Curalta to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature

Allergy Questions

Do you have any material, medication or food allergies? Yes / No

If Yes, what is your allergy? (Circle all that apply)

epinephrine / aspirin / codeine / penicillin / cortisone / iodine / sulfa / tetracycline

erythromycin / Demerol / morphine / latex / Levaquin / Cipro / seafood / adhesive

Other: _____ Other: _____ Other: _____ Other: _____

Current Prescription Medication

Are you currently taking any prescription or over-the-counter medications? Yes / No

If Yes, Please complete below;

Name of Medication

Name of Medication

Medical Conditions

Do you have any medical conditions? Yes / No

If Yes, please circle all that apply, **even if you are taking medication for the condition**

- | | | |
|----------------------------|-----------------------------|--------------------------|
| Alzheimer's or memory loss | anemia | anxiety |
| atrial fibrillation | back problems | bleeding disorder |
| cancer, type_____ | COPD | congestive heart failure |
| coronary artery disease | diabetes | GERD |
| glaucoma | hearing loss | heart valve problem |
| hearts attack or MI | heart problem | hepatitis |
| high cholesterol | HIV or AIDS | hypertension |
| kidney disease | liver disease | migraines |
| Parkinson's | peripheral arterial disease | peripheral neuropathy |
| prostate problem | psoriasis | Raynaud's |
| rheumatoid arthritis | seizure disorder | skin cancer |
| stroke or TIA | thyroid problem | vision problems |
| other_____ | other_____ | other_____ |

Surgeries

Have you had any surgeries? Yes / No (If Yes, please circle all that apply)

appendix	back	bariatric
bladder	bypass legs	bypass heart
cataract	colon	gallbladder
heart valve	kidney	liver
Organ transplant, organ_____	prostate	replacement hip
replacement knee	thyroid	vein stripping
other_____	other_____	other_____

Social and Immunization History

Smoking

Do you currently smoke cigarettes? Yes / No

If yes, how many packs per day do you smoke? Less than 1 / 1 pack / > 1 pack per day

Have you smoked in the past? Yes / No

If yes, when did you quit? This year / 1-5 years ago / More than 5 years ago

Do you drink alcohol regularly? Yes / No

If yes, how much? Socially / 1 drink per week / 1 drink per day / 1 or more per day

Flu & Pneumonia Vaccine

Have you had a flu shot this year? Yes / No

If yes, when,_____

Have you had a pneumonia (pneumococcal pneumonia) vaccine? Yes / No

If yes, when,_____

Have you had a COVID vaccine this year? Yes / No

If yes, when,_____

Height: _____ **Weight:** _____ **BP:** _____ **Shoe Size:** _____

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, _____ hereby authorize Curalta Foot and Ankle Associates (the practice) to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize the practice to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I request payment from my insurance company or Medicare to be made directly to the practice. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. This authorization may be revoked at any time by me with written notice to the practice. Most insurance plans require that patient authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient cannot sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We cannot call your doctor to request a referral on your behalf. If you have a co-pay, it is due at the time of the visit. If you fail to pay your copay at the time of the visit, a \$5.00 surcharge will be applied for each month until the balance is paid. We do not bill for copay.

Regardless of your insurance plan, you are financially responsible for payment. If the claim we submit is not paid by your insurance plan within 90 days, we consider the claim as "not covered" by your plan, and you will become financially responsible. Should your account go to collection, you agree to pay any and all expenses, including collection fees or percentages.

Acknowledgement of Practices Notice of Privacy Practices

By signing my name below, I acknowledge that I am aware that a copy of the Notice of Privacy Practices (NPP) is available to me (copy located in waiting room) and I have had the opportunity to read, if I so chose, and understand the Notice of Privacy Practices (NPP) and agree to its terms. I may request and receive a printed copy of the NPP upon request.

MEDICARE PATIENTS ONLY: I request that payment of authorized medical and surgical benefits and supplies be made to Curalta Foot and Ankle Associates on my behalf or any covered dependants. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS: As a self-paying patient I understand that I am responsible for and will pay for all medical/podiatric services at the time of the visit.

I have read, understand and agree to the above.

_____/_____/_____

Today's Date

Patient's Name (Please Print)

Patient's Signature

If under 18 years old, Patient's or Guardians Name
Print)

If under 18 years old, Patient's or Guardians Signature (Please

**Designation Of Patient Spokesperson
(PHI)**

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information: Please Print

Patient Name: _____ Date Of Birth: _____
Address: _____ Phone #: _____

Authorized Individual: Please Print

Name: _____ Relation To Patient: _____
Address: _____ Phone #: _____

I grant to the individual named above to have access to:

- _____ All of my PHI
- _____ Other- Specify limits or specific health care incident

1. I understand that I may revoke these designations at any time by notifying the appropriate Curalta Foot & Ankle Associates in **writing**; however, if I do revoke the authorization, it will not have any effect on any actions taken by Curalta Foot & Ankle Associates prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPPA
4. I understand that this authorization will: (Must check one)
() expire 1 year from the date executed
OR
() be effective for the lifetime of the patient unless revoked

Signature of Patient/Personal Representative: _____

Name Of Personal Representative: _____ Date: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS FORM