

Dwight S. Blease, DPM

Casco Bay Podiatry -
Active Foot & Ankle
10 Cushing Street, Brunswick, ME 04011
207-725-2800 / fax 207-725-6221

Welcome to the Office!

REASON FOR TODAY'S VISIT:

TODAY'S DATE:

D.O.B. - -

Last Name _____ First Name _____ MI _____ Age: _____

Preferred Name: _____ Gender: F / M _____

Address: _____
Street _____ City/Town _____ State _____ Zip Code _____

Phone: Home: _____ Primary Care Physician: _____

Work: _____ PCP Address: _____

Cell: _____ Pharmacy Name: _____

Email: _____ Pharmacy Location: _____

Occupation: _____ Employment: Full-Time Part-Time Self-Employed Retired Unemployed

Employer: _____ Job Duties: _____

Marital Status: Married Single Partner Separated Divorced Widowed

Please answer the following ETHNICITY question, part of a federal mandate
RACE: WHITE BLACK/AFRICAN AMERICAN AMERICAN INDIAN ASIAN HISPANIC/LATINO/SPANISH
 OTHER _____ (please specify) I DECLINE

Emergency Contact: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Guarantor

(Person responsible for paying the bills)

Patient's Relationship to Guarantor: Self Spouse Employee Child (Father's Insurance) Child (Mother's Insurance)

Guarantor Last Name: _____ Other (Please Explain): _____

Guarantor First Name: _____ M.I. _____

Guarantor D.O.B. - - _____

Guarantor Address (for billing purposes): _____
Street _____ City _____ State _____ Zip Code _____

Insurance Policy Holder

(If different from Patient)

Patient's Relationship to Policy Holder: Self Spouse Employee Child (Father's Insurance) Child (Mother's Insurance)

Policy Holder's Last Name: _____ Other (Please Explain): _____

Policy Holder's Name: _____ M.I. _____

Policy Holder's D.O.B. - - _____

Policy Holder's Address: _____
Street _____ City _____ State _____ Zip Code _____

Dwight S. Blease, DPM
Casco Bay Podiatry
Active Foot & Ankle

10 Cushing Street, Brunswick, ME 04011
 207-725-2800 / fax 207-725-6221

PATIENT NAME: _____

Patient Medical History

CONDITION	SELF	FAMILY	IF FAMILY, WHO?
Arthritis			
Cancer: type:			
Cardiovascular:			
Atrial Fibrillation (Afib)			
Chest Pain			
Congestive Heart Failure			
Heart Attack			
High Blood Pressure			
Mitral Valve Prolapse			
Stroke/TIA			
Pacemaker			
Palpitations/Arrhythmia			
Endocrine:			
Diabetes (insulin)			
Diabetes (non-insulin)			
Avg. Blood Sugar:			
Avg. A1C:			
Thyroid Disease			
Eye Disease:			
Gout			
Gastrointestinal:			
Crohn's Disease			
GERD (Reflux/Heartburn)			
Hematologic/Lymphatic:			
Anemia			
Bleeding Disorders			
DVT/Blood Clotting/PE			
Infections:			
MRSA			
Infectious Disease:			
Hepatitis			
Herpes			
HIV/AIDS			
Infectious Skin Infection			

CONDITION	SELF	FAMILY	IF FAMILY, WHO?
Kidney Disease:			
Kidney Failure			
Dialysis			
Liver Disease:			
Hepatitis A, B, or C			
Lung Disease:			
Asthma			
COPD			
Emphysema			
Shortness of Breath			
Tuberculosis			
Memory Loss			
Musculoskeletal:			
Back Pain			
Fibromyalgia			
Joint Pain/Swelling			
Leg Cramps			
Morning Stiffness			
Muscular Tenderness			
Neck Pain			
Osteoporosis			
Stiffness			
Weakness of Muscles			
Difficulty with Walking			
Neurological (Nerve Issues):			
Seizure Disorder			
Tremors			
Multiple Sclerosis			
Numbness			
Parkinson's Disease			
Burning in Feet			
Tingling in Feet or Toes			
Prostate			
Psychiatric			

Medications (please list or provide a copy)

Are you Allergic or Sensitive to? No Known Allergies

Penicillin Sulfa Vicodin Codeine Iodine
 Tape Latex Other Allergies (list): _____

Surgeries

Year

Hospital & Surgeon

Surgeries	Year	Hospital & Surgeon

Do you smoke cigarettes? **Y/N** 1/4 pack/day 1/2 pack/day 1 pack/day 2 packs/day >2 packs/day Cigars Pipe Chewing Tobacco
 If NO, did you smoke in the past? **Y/N** If yes, how many years did you smoke? _____ Quit year? _____

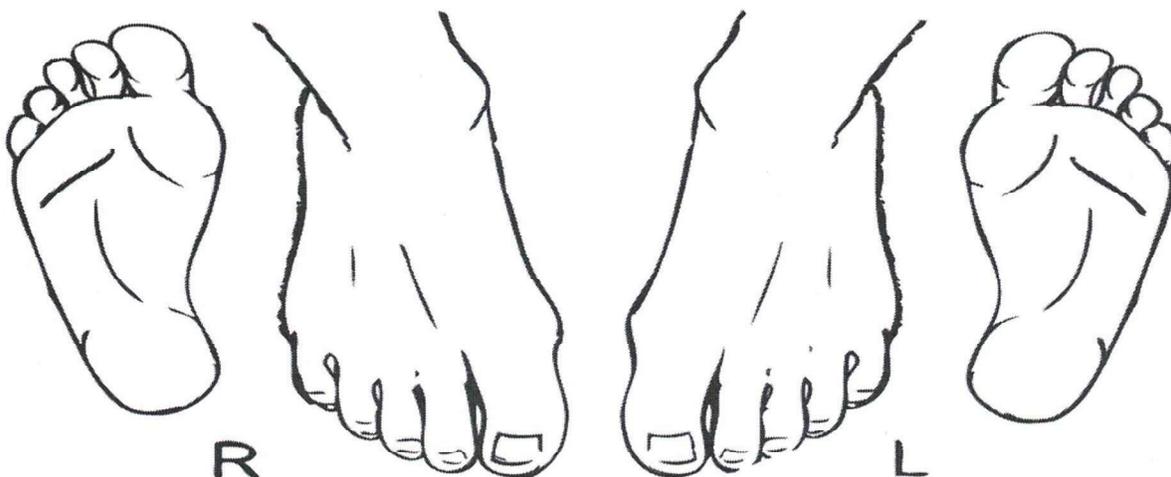
Do you drink alcohol? **Y/N** Socially 1 Daily 2 Daily 3 Daily >3 Daily Preferred Beverage(s): _____

How often do you exercise? Rarely/Occasionally 1-2 Times a week 3-4 Times a week 5-6 Times a week Daily

Describe your exercise routine: _____
 _____ if walking, running, or cycling how far do you go in a week? _____

TODAY'S DATE: _____

Current Chief Complaint/History of Present Illness



Indicate the location of your problem or pain on the diagrams above.

Describe the pain: Sharp Dull Aching Throbbing Burning Shooting Stabbing Electrical

Indicate the severity of pain/discomfort

None Light Moderate Strong Severe

Please indicate pain level 0 1 2 3 4 5 6 7 8 9 10

How long ago did pain/discomfort start?

Years Months Weeks Days Hours

Pain occurs while

Walking Standing Running Wearing Shoes At Rest All the Time

Does the pain/discomfort cause difficulty with daily activity?

Is this problem work related? Yes No

SHOE SIZE:

HEIGHT:

WEIGHT:

Dwight S. Blease, DPM
Casco Bay Podiatry - Active Foot & Ankle
10 Cushing Street, Brunswick, ME 04011
207-725-2800

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Casco Bay Podiatry to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any coinsurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Medicare: I authorize the release of any information necessary to process medical claims for Casco Bay Podiatry and authorize that payment of Medicare benefits for these claims be made to this office. Also, I agree to pay promptly for any services not covered by Medicare and or determined by Medicare to be my responsibility (i.e., Deductibles, Co-payments dictated by Medicare such as 20% of the allowable fee for Medical Services and any charges for Services not covered or deemed "Not Reasonable and Necessary" by Medicare).

Consent and acknowledgement of Medical Privacy Notice: It is the policy of Casco Bay Podiatry that health care information is confidential and shall not be improperly disclosed. Your healthcare information shall not be disclosed unless disclosure is permitted or required by law, or you have specifically authorized the disclosure. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement. I am entitled to a copy of this consent upon request.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian Signature: _____ Date: _____

Name Printed: _____

If not patient, relationship _____

Dwight S. Blease, DPM
Casco Bay Podiatry – Active Foot & Ankle
10 Cushing Street, Brunswick, ME 04011
207-725-2800 / fax 207-725-6221

Thank you for choosing us as your foot care provider. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. It is necessary for us to collect co-payments and deductibles from patients by law. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Insurances.** We will provide any information necessary to process medical claims for Casco Bay Podiatry. Patients will promptly pay for any services not covered by your insurance or deemed "not reasonable and necessary" by your insurance.
- 6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed to you.
- 7. Returned checks.** There is a service fee of \$40 for all returned checks.
- 8. Cancelled/Missed appointments.** Our policy is to charge \$50 for appointments missed or cancelled less than 24 hours prior to the appointment. This charge will be your responsibility and billed directly to you. You will be asked to pay this before your next appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date