Scott W. McKinney, DPM
Jorge Cuza, DPM
Angela Dagley, DPM
Mark Moss, DPM
Francisco Cuza, DPM

HELLO! WELCOME TO OUR OFFICE!

Please print the following information.

Date ___________ This information is important for our records and your health.

Patient Name: ______________________________ Birthdate: ___________________ Age ______

Address: ____

City _______________________________________ State _______________ Zip ______________

Home phone _______________________________ Email _________________________________

Work phone _______________________________ Employed by ___________________________

Work address ____ City ____________________

State _________ Zip ____________ Sex: M F Marital Status: S M D W

Social Security No __________________________ Family Physician _________________________

Referred to our office by ____

Contact in case of emergency ________________ Phone No _____________________________

Insured's Name ____________________________ Relationship __________________________

Insured's Employer _________________________ Insured's work # ________________________

Insured's SS # ____________________________ Insured's Birthdate _______________________

Primary Insurance ___________________________ Address ______________________________

Group # ______________________________

Secondary Insurance _______________________ Address ______________________________

Group # ______________________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

____
Signature

Nature of foot problem ____

My foot problems involve my ______ Left foot ______ right foot ______ both feet

It has troubled me for __________ weeks ______ months ________ years

Have you had previous care by a Podiatrist? ______ Yes How recently? ____________ ______ No

Shoe Size ____________ Weight ____________ Height _______________

Please continue to the next page

Please circle “yes” or “no to the following questions:

Are you now or have you been under a doctor’s care during the past two years	Yes	No
Are you subject to prolonged bleeding	Yes	No
Have you had a recent weight gain or loss	Yes	No
Do you ever experience numbness or tingling in your feet or legs	Yes	No
Have members of your immediate family (parents, grandparents, or Children) ever had foot problems similar to yours	Yes	No
Do your ankles turn, roll in, or sprain easily	Yes	No
Do you ever have stiffness in your foot joints in the morning or evenings	Yes	No
Do you ever get pains, cramps, tightening of the muscles in your feet/legs	Yes	No

Does your job require _____walking _____standing _____both

Number of hours averaged on your feet each day _________________

How is your general health _____ good ______ fair _____ poor

Have you ever been treated for any of the following?

____ Diabetes	____ Tumors or Growths	____ Liver Problems
____ Stomach Ulcer	____ Difficulty in Hearing	____ Anemia
____ Rheumatic Fever	____ Epilepsy	____ Stroke
____ Shortness of Breath	____ Tuberculosis	____ Varicose Veins
____ High Blood Pressure	____ Kidney Problems	____ Blood Clots or Phlebitis
____ Grout	____ Heart Trouble	

Are you taking any medicine at the present time? _____ Yes _____ No

If yes, please list: ____

____

Have you ever experienced any adverse effects from any of the following?

____ Penicillin	____ Aspirin	____ Cortisone
____ Novocain	____ Tape	____ Codeine
____ Sulfa Drugs	____ Any Antibiotic	____ Other (please list)

____

List any serious illnesses: ____

____

List all operations ____

____

I HEREBY GIVE MY PERMISSION TO THIS OFFICE TO EXAMINE AND TREAT MY FEET AS INDICATED

Date_____________________________ Signature __________________________________

MCKINNEY PODIATRIC ASSOCIATES, P.A.

Scott W. McKinney, DPM
Jorge Cuza, DPM
Angela Dagley, DPM
Mark Moss, DPM
Francisco Cuza, DPM

POLICY FOR INSURANCE PPO'S AND HMO'S

If you are covered under an HMO or PPO insurance with your company, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your card and/or referral BEFORE SERVICES ARE RENDERED. Should you NOT have your insurance card and/or referral with you at the time of service, you will be asked to either pay in full for services rendered or re-schedule your appointment for a time when you can bring the insurance card and/or referral.

DEDUCTIBLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BLANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE WHICH IS DUE WITHIN 30 DAYS AFTER YOUR RECEIVE YOUR FIRST STATEMENT.

The majority of services rendered in this office are considered office surgery by your insurance company. This may result ion a higher co-payment or charges may be subject to a surgical deducible. As a result, you may be responsible for a higher co-payment, payment of surgical deductible and/or full payment of services rendered at the time of your visit.

If you understand and agree with this policy, please sign below.

Thank you,

Drs. McKinney, Cuza, Dagley, Moss and Cuza.

________________________________ ____________________________

Patient's 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 Name (please print) Date

____

Parent of Authorized Representative (if applicable)

____

Signature