WELCOME TO MY OFFICE
UNIVERSITY FOOT AND ANKLE CENTER, LLC
Genine M. Befumo, D.P.M.
Diplomate American Board of Podiatric Surgery

Patient Name: _____ **Date of Birth:** __/__/__ **Age:**___ **Sex: M F**
Last First MI

Home Address: _____ **City/State:** _____ **Zip:** _____

Social Security #: ____-____-____

Home Phone #: (____) _____-_____ **Please designate Primary Phone #:**
Cell Phone #: (____) _____-_____ ___ **Home** ___ **Cell** ___ **Work**
Work Phone: (____) _____-_____

Email Address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** (____)-____-____

Primary Care Doctor: _____ **City/State:** _____ **Phone #:** (____)-____-____

How did you hear about us? ____ **Doctor Referral:** _____
Name

____ **Insurance Company** ____ **Friend/Family** _____
Name

_____ **Google/Internet** ____ **Facebook**

INSURANCE INFORMATION

Primary Insurance Company Name: _____
Primary Insurance Company Address: _____
Responsible Party Insured Name: _____ Date of Birth: _____
Policy #: _____ Group #: _____

Social Security # of Insured Party: ____-____-____

Secondary Insurance Company Name: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS:

Under the requirements of HIPAA, we are not allowed to give out medical information to anyone with patient's consent. If you would like any medical or billing information discussed with family members, you must sign below and list family members authorized.

I hereby authorize University Foot and Ankle Center, LLC to release my medical/billing information to the Following individuals:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:

I have been notified of University Foot and Ankle Center, LLC HIPAA policy and am aware I may obtain a copy of privacy practice if I wish.

Signature: _____ Date: _____

HAVE YOU HAD YOUR VACCINE? Please check:

_____ Covid 19 Date: _____
_____ Influenza
_____ Pneumonia (if over age 65)
_____ NONE

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

ALLERGIES: _____ Penicillin _____ Sulfa Drugs _____ Iodine ____ Latex _____ Local Anesthesia
_____ OTHER

RACE: ___ American Indian ____ Asian ___ Black/African American ___ Hispanic ____ White

ETHNICITY: ____ Hispanic ____ Not Hispanic

CHIEF COMPLAINT:

WHAT SPECIFIC FOOT AND/OR ANKLE PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

Please describe pain, duration of problem and/or any treatment you have received.

MEDICAL HISTORY (please check all that apply)

___ Alzheimer's
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Bleeding disorders
___ Cancer
___ Chest Pain
___ Clotting disorders
___ Congestive heart failure
___ COPD
___ Crohn's disease
___ Irritable bowel syndrome
___ Keloid/thick scar
___ Kidney disease
___ Liver disease
___ Lyme's disease
___ Multiple sclerosis
___ Neuropathy
___ Osteoporosis
___ Pacemaker
___ Palpitations/Arrhythmia
___ Phlebitis
___ Poor circulation

___ Diabetes 1
___ Diabetes 2 (insulin dependent)
___ Diabetes 2 (non-insulin dependent)
___ Epilepsy
___ Fibromyalgia
___ Gout
___ Hearing disorder
___ Heart attack
___ Hepatitis
___ High blood pressure
___ History of DVT/blood clotting
___ HIV
___ Hypertension
___ Prostate cancer
___ Prostate enlargement
___ Psychiatric disorder
___ Recurrent urinary tract infection
___ Reflux/heartburn
___ Sciatica
___ Seizure disorder
___ Shortness of breath
___ Stomach ulcer
___ Stroke/TIA
___ Thyroid problem
___ Ulcerative colitis
___ Vascular disease
___ NONE OF THE ABOVE

SOCIAL HISTORY

___ Single ___ Married ___ Divorced ___ Widowed

Employer: _____ Occupation: _____
Regularly Exercise: _____ Yes _____ No
Use of Alcohol _____ Never _____ Socially _____ History of Alcohol Abuse
Use of Tobacco _____ Never _____ Quit _____ # Years _____ # of Packs/Day
_____ Vaping _____ Never _____Frequency
_____ Marijuana _____ Never _____ Frequency
Other Recreational Drugs _____

FAMILY HISTORY:

	Mother	Father	Brother	Sister	Other
Arthritis					
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Stroke					
Thyroid					
Other:					

REVIEW OF SYSTEMS:

Are you currently suffering from any of the following:

CONSTITUTIONAL :

___ Fevers
___ Chills
___ Sweats
___ Loss of Appetite
___ Fatigue
___ Nausea
___ Vomiting
___ Weight Loss (unintentional)

UROLOGICAL:

___ Painful Urination
___ Blood in Urine
___Unusual Vaginal Discharge
___ Increased Frequency of Urine

ENT:

___ Blurred or Double Vision
___ Eye Pain or Irritation
___ Eye Discharge
___ Failing Vision
___ Cataract
___ Sensitivity to Light
___ Earaches
___ Ears Ringing
___ Decreased Hearing
___ Difficulty Swallowing
___ Frequent Nose Bleeds
___ Frequent Sore Throat
___ Prolonged Hoarseness
___ Sinus Trouble or Congestion

SKIN:

___ Skin rashes
___ Itching
___ Chronic Dry Skin
___ Suspicious moles or other skin abnormalities you are concerned about

CARDIOVASCULAR:

___ Chest Pain
___ Fainting Spells
___ Heart Palpitation (fast, irregular heart)
___ Shortness of Breath
___ Ankle Swelling

LYMPHATIC:

___ Excessive Bruising
___ Excessive Bleeding
___ Swollen Glands (in Neck, Armpits, or Groin)

RESPIRATORY:

___ Chronic Cough
___ Shortness of Breath
___ Chronic Wheezing
___ Coughing up Blood
___ Excessive Phlegm

GASTROINTESTINAL:

___ Persistent Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Jaundice (yellow skin)
___ Change in Appearance of Stool
___ Chronic Abdominal Pain
___ Bloody or Very Black Stool

MUSCULOSKELETAL:

___ Back Pain
___ Joint Pain/Swelling
___ Muscle Cramping
___ Muscle Weakness/Stiffness
___ Arthritis

NEUROLOGIC:

___ Headaches
___ Weakness
___ Numbness
___ Seizures
___ Dizziness
___ Fainting Spells
___ Tremor, Hands Shaking
___ Unable to Move Parts of Your Body at times

VASCULAR:

___ Leg or Calf Pain
___ Night Cramps
___ Rest Pain
___ Swelling
___ Bleeding or Clotting Disorders
___ Easy Bruising

PRIOR SURGERIES:

___ ACL Reconstruction
___ Amputation of Toe
___ Foot Surgery
___ Artificial Joint Replacement
___ Foot Surgery
___ Kidney Surgery
___ Stent Insertion
___ Vascular Surgery

CURRENT MEDICATIONS:

Please check here if no prescription medications: _____

Medication Name	**Dose**	**Reason**

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and the office staff of any changes in my medical status.

Patient's Signature _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. Up-to-date insurance cards and payment for each visit is required at the time of service. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copays and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare of other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility.

CLAIM SUBMISSION: We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with an additional $50 fee. Payment arrangements can be made on a case-by-case basis. We accept Checks, Cash and Credit cards. An additional $35 fee will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to **University Foot & Ankle Center, LLC** for medical services provided. I agree to pay **University Foot & Ankle Center, LLC** for any balances unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **University Foot & Ankle Center, LLC.** I understand that I am responsible for payment of deductibles, copayment, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to patient: _____ Date: _____