Practice: Steven S. Blanken, DPM **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Rev 1/21/2015

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
- ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
- ☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
- ☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
- ☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis ?
- ☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2) How long: ____
- ☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA A1C# ____
- **Are you pregnant?** ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐Yes ☐No

Social History

Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?

Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely

Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____

☐Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

- ☐ Alzheimer's _____
- ☐ Arthritis _____
- ☐ Bleeding disorders _____
- ☐ Blood clot _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Circulation problems _____
- ☐ Other (specify): _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Emphysema _____
- ☐ Heart disease _____
- ☐ High Blood Pressure _____
- ☐ Neurological _____
- ☐ Strokes _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking ☐fainting	☐fever ☐palpitations	☐chest pain/pressure ☐vascular disease	☐leg swelling ☐valve problems	☐cold hands/feet ☐**NONE**
Genitourinary	☐blood in urine ☐decreased frequency	☐hesitancy ☐excessive urination	☐incontinence ☐kidney disease	☐increased urgency ☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain ☐diarrhea	☐heartburn ☐trouble swallowing	☐blood in stool ☐vomiting ☐decrease appetite	☐ulcers ☐increase appetite	☐constipation ☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids ☐itchiness	☐dry, scaly skin	☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease ☐anemia	☐blood thinners	☐clotting disorder	☐**NONE**
Neurological	☐tingling ☐tremors	☐weakness ☐paralysis	☐seizures	☐numbness	☐headaches ☐**NONE**
Musculoskeletal	☐back pain ☐sciatica	☐joint swelling ☐joint stiffness	☐muscle weakness ☐joint pain ☐joint instability	☐muscle pain ☐arthritis	☐neck pain ☐**NONE**
Respiratory	☐chest pain ☐shortness of breath	☐wheezing ☐emphysema	☐COPD	☐coughing	☐snoring ☐**NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: Steven S. Blanken, DPM **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: _____ ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Shoe Size: Width:

Current Medications

☐No Known Medications ☐I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

☐No Known Allergies ☐No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Advanced Directives: ☐Living Will ☐DNR ☐Durable Power of Attorney ☐Surrogate Appointed ☐None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Patient's Authorization

I authorize Steven S. Blanken, DPM/or FACBMC to apply for benefits on my behalf for services rendered by Steven S. Blanken, DPM/FACBMC. I request payment from my insurance company to be made directly to Steven S. Blanken, DPM/FACBMC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date

Notice of Privacy Practices

I have received a NOTICE OF PRIVACY PRACTICES from Dr. Steven Selby Blanken/ Blanken Podiatry Group/ Foot and Ankle Center at The Burkland Medical Center, Inc. I understand that it is my obligation to read this notice thoroughly as this notice being effected starting April 14, 2003. (Posted on the wall or ***A copy can be provided upon request***)

_____

Print Name

_____ _____

Signature Date

Cancellation Policy

Kindly give us a 24hr notice if unable to keep the appointment unless due to illness or uncontrolled circumstances. There is a $50.00 fee for same-day cancellation or a no-show. An increase of $25.00 will apply to repeated no-shows.

_____

Signature and Date

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We would like to welcome you and thank you for selecting us for your foot care. We are committed to providing you with the best possible care. If you have any medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

Payment, copay or coinsurance for service is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, and credit cards for services rendered. We will file the claim on your behalf. Any such requests must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

Balances older than 30 days may be subject to interest charges of 1.5% per month. Returned checks are subject to an additional fee of $35 subject to change at Dr. Blanken's and staff's discretion. Additionally, a charge of $50 will be levied for broken or missed appointments without 24 hours advance notice. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

However, you must realize that 1) Your insurance is a contract between you and/or your service provider. We are not a party to that contract. 2) Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to a company whose percentage (such as 50% or 80%) of "U.C.R.." "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and/or the cost of care in this area. 3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. 4) Medicare patients must realize that we will participate with their insurance. However, you are responsible for your 20% co-insurance, deductible and any non-covered services. Certain co-insurances are automatically forwarded by Medicare to your supplemental insurance company. If your company, after Medicare has provided its reimbursement for services rendered, does not respond within 30 days, you become responsible for the amount due.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems should arise, we encourage you to contact us promptly for assistance in the management of your account. If a patient defaults on balances/payments, they may be subject to collections and fees associated with collections, including reasonable attorney fees.

Patient Signature _____ Date _____