Total Foot Care, P.A. - Dr. Alexander Terris, DPM
2700 Silverside Rd. Ste 3B ● Wilmington, DE 19810

Mr. Mrs. Miss. Ms. Dr. ____
First Name Middle Initial Last Name

Address: ____
Street City State Zip

Date of Birth: ____/____/____ **Age:** ____ **SSN:** ____-____-____ **Sex:** Male____ Female____

Email: ______________________ **Marital Status:** Single____ Married ____ Other______

Telephone: Home ______________ Cell ______________

May we leave messages at the above numbers if we need to contact you? No____ Yes____

Emergency Contact: ____________ **Relationship to Patient:** ____________ **Phone #:** ____________

Have you completed an Advance Directive (living will)? No____ Yes____

How did you hear about us? (circle one) **Internet/Google** **Friend/Family** **Doctor referral ?** ____________
Other ______________________

Describe the primary reason for this visit: ____

____

How long has it been bothering you? __________ **Describe the pain:** Sharp____ Dull____ Throbbing____ Shooting____

How severe is it? Minimal ____ Mild____ Moderate____ Severe____

Does anything aggravate the problem? No____ Yes____, What? ______________________

Does anything make it feel better? No____ Yes____, What? ______________________

When does it bother you the most? Standing____ Walking____ Morning____ Night____ All the time____

Any past foot problems? No____ Yes____, What? ______________________

Shoe Size: ________ **Height:** ________ **Weight:** ________ **Blood Pressure:** ________ / ________

What is your occupation? ______________________ **Do you:** Stand____ Sit____ Stand and Sit____

Are you required to wear any particular type of work shoe? No____ Yes____, what type? ____________

Insurance Information

Primary Insurance: ______________ Policy Holder: ______________ DOB____/____/____
Policy ID #: ______________ Group #: ______________

Secondary Insurance: ______________ Policy Holder: ______________ DOB____/____/____
Policy ID #: ______________ Group #: ______________

**All office visit charges and co-pays are due at the time services are rendered. It is the patient themselves whom are responsible for their financial aspects of services rendered. There will be a charge for returned checks, missed appointments without 24 hours notice and completion of any forms. I agree to pay for all deductibles, co-pays, non-covered services and any portion of covered services not paid in full by my insurance plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. I hereby name Total Foot Care, P.A. (TFC) as my assignee. I instruct my health care benefits plan administrator, i.e. PLAN to pay TFC directly for all professional and medical services provided by TFC, through the means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed to TFC. I AUTHORIZE THE RELEASE IF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.*

X ______________________ **Relationship to patient** (if applicable) ____________ **Date** ____/____/____
Signature of patient or patient's representative

Race: American Indian or Alaska Native_____ Asian_____ Black or African American______
Native Hawaiian or Pacific Islander_____ White_____ Decline to Specify____

***This information is requested due to Healthcare Reform laws dictated by Congress.**

Ethnicity: Hispanic or Latino_____ Non-Hispanic or Non-Latino_____ Decline to Specify_____

Preferred Language: English ____ Spanish ____ Other: ____________________

Primary Care Physician: ____________________________________ Phone #: ___________________________ Date Last Seen: ______/______/_____

Address: ____

Pharmacy: ______________________________ Phone #: _____________________Address: ____

Current Medications: (Use the back of this form if more room is needed or attach a separate page) **No Known Medications** _____

Name: ____ Dose: _________________________

Name: ____ Dose: _________________________

Name: ____ Dose: _________________________

Name: ____ Dose: _________________________

Allergies: Are you allergic or sensitive to any of the following? **No Known Allergies** _____

Penicillin	Yes / No	**Aspirin / Advil / Aleve**	Yes / No
Sulfa Drugs	Yes / No	**Novocain / Lidocaine**	Yes / No
Codeine	Yes / No	**Iodine / Shellfish**	Yes / No
Morphine / Demerol	Yes / No	**Adhesive Tape / Latex**	Yes / No

Other: ____

Are you pregnant? No____ Yes____ **Are you nursing?** No____ Yes____

Surgical History

Have you had any major surgeries? No_____ Yes _____(please list) ____

____

Do you have any artificial joints? No_____ Yes_____, Which joints? ____

Do you have an artificial heart valve? No_____ Yes_____

Social History

Do you drink alcohol? Never___ Past ____ Yes____, How often? Daily____ 1-2 x Week _____ 1-2 x Month ____ 1-2 x Year _____

Do you smoke? No____ Yes____ - Cigarettes ___ Cigars ____ How many per day? _________

Have you smoked in the past? No____ Yes____, How many per day? ________, Method of Quitting: ____________________

Do you have/have had a substance abuse problem? No____ Yes____, Please specify: ____

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.

X ____ **Relationship to patient** (if applicable) __________________ **Date** ____/_____/_____

Signature of patient or patient's representative

Review of Systems: Do you currently have or have had any of the following in the last year? If none, please check "NONE" at the end.

Constitutional: Weight Loss___ Fever___ Chills___ Sweats___ Weakness___ Fatigue___ Decreased Activity___ NONE___

Eyes: Glasses or Contacts___ Blurry Vision___ Visual Disturbances___ Discharge___ NONE___

ENT: Decreased Hearing___ Ear Pain___ Nasal congestion___ Sore Throat___ NONE___

Respiratory: Shortness of Breath___ Chronic Cough___ Sputum Production___ Wheezing___ Apnea___ COPD___ Snoring___ Emphysema___ NONE___

Cardiovascular: Chest Pain___ Palpitations___ Bradycardia___ Tachycardia___ Peripheral Edema___ Syncope___ NONE___

Gastrointestinal: Nausea___ Vomiting___ Diarrhea___ Constipation___ Heartburn___ Abdominal Pain___ NONE___

Genital Urinary: Dysuria___ Hematuria___ Change in Urine Stream___ Urethral Discharge___ Lesions___ NONE___

Hematologic: Bruising Tendency___ Bleeding Tendency___ Swollen Lymph Glands___ Clotting Disorder___ NONE___

Endocrine: Excessive Thirst___ Polyuria___ Cold Intolerance___ Heat Intolerance___ Excessive Hunger___ NONE___

Allergic/Immunologic: Immunocompromised___ Recurrent Fevers___ Recurrent Infections___ Malaise___ NONE___

Musculoskeletal: Back Pain___ Neck Pain___ Joint Pain___ Muscle Pain___ Decreased ROM___ Trauma___ NONE___

Skin: Rash___ Pruritus___ Abrasions Breakdown___ Burns___ Dryness___ Lesion___ Hypertrophic/Keloid Scar___ NONE___

Neurologic: Alert & Oriented x4___ Abnormal Balance___ Confusion___ Numbness___ Tingling___ Headaches___ NONE___

Psychiatric: Excessive Worry___ Depression___ Thoughts of Harming Yourself or Others___ NONE___

Medical History Do you have or have you ever been treated for any of the following? If none, please check "NONE" at the end.

___Abnormal Bleeding
___Abnormal Healing
___Allergies (seasonal)
___Alzheimer's
___Anemia
___Anxiety
___Asthma
___Bladder Problems
___Blood clots
___CVA
___Cancer
___Dementia
___Depression
___Diabetes
___Emphysema
___Epilepsy
___Frequent Infections
___GERD (Reflux)
___Glaucoma
___Hearing/Ear Disorder
___Heart Attack
___ (Other) Heart Conditions
___Hepatitis, Liver Disease
___High Blood Pressure
___High Cholesterol
___HIV
___Intestinal Problems
___Kidney Disease
___Lung Disease
___Lyme's Disease
___Mental Illness
___Migraine Headaches
___Neurological Problems
___Neuropathy
___Osteoarthritis
___Osteoporosis
___Pacemaker
___Phlebitis
___Poor Circulation
___Psychiatric Problems
___Rheumatic Fever
___Rheumatoid Arthritis
___Sciatica
___Spinal/Disc Disorder
___Stomach Ulcer
___Stroke
___Thyroid Disorder
___Tuberculosis
___Unexplained Weight Loss
___**NONE**
Other ____________________
____

Family History Please list any immediate family members (**Mother, Father, Sister, Brother**) who have or have had any of the following:

Negative _____ Unknown _____ Adopted _____

Alzheimer's ____________________
Arthritis ____________________
Bleeding Disorder ____________________
Blood Clot ____________________
Bunions ____________________
Cancer ____________________
Circulation Problem ____________________
Depression ____________________
Diabetes ____________________
Emphysema ____________________
Hammertoes ____________________
Heart Attack ____________________
High Blood Pressure ____________________
Neurological Issues ____________________
Stroke ____________________
Other (specify) ____________________

*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. * I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will **not** be published as part of medical research or disbursed in any way without my permission.*

X ____________________ **Relationship to patient** (if applicable) ____________ **Date** ____/____/____
Signature of patient or patient's representative

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Total Foot Care, PA. and I have read (or had the opportunity to read if I so choose) and understood the Notice.

X ______________________________________   __________________

Patient Name (please print)   Date

____

Parent or Authorized Representative (if applicable)

X ______________________________________

Signature

Total Foot Care is now providing you with online access to your health records and the ability to communicate with our office.

This portal will give you a personal view into the electronic medical records that your doctors and nurses at Total Foot Care use to manage and document your care. **It allows you to communicate with your physicians and nurses, request appointments, update changes in medications, address, phone number or insurance coverage, request prescription refills and view your medical records in a secure, efficient and easy-to-use manner.**

IQ Health's timesaving benefits empower you to take control of your health – anytime, anywhere.

Fill in the needed information below and we will send you an emailed invitation to join Total Foot Care's Patient Portal.

Patient Information ☐ I Decline the use of this portal to control my health care *(signature required below)*

First Name: ____________________ Middle Initial: ________ Last Name: ____________________

Date of Birth: _____/ _____/ _____ E-Mail Address *(required)*: ______________________________

Security Question: *(choose one below)*

Last 4 digits of SSN: ___ ___ ___ ___ ***OR*** Mother's birth year: ___ ___ ___ ___

Signature: ______________________________

As of 2/1/19 we support Health Records on iPhone - which brings together hospitals, clinics and the existing Apple Health app to make it easy for patients to see their available data from multiple providers whenever they choose. You will have access to medical information from participating institutions organized into one view – covering allergies, conditions, immunizations, lab results, medications, procedures and vitals. Apple's Health Records data is encrypted and protected with the user's iPhone passcode, Touch ID or Face ID.

For more information on Health Records, visit: https://www.apple.com/healthcare/health-records/

Notice of Privacy Practice

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
This notice describes how health information about you, the patient, may be used and disclosed, and how you can get access to your individually identifiable health information.

Please read this information carefully.

Total Foot Care, P.A. is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the treatment and services necessary to keep you in good health. We are required by law to keep your health care information confidential. We are also required by law to provide you this notice of our legal responsibilities. According to federal and state laws, and without your authorization, we can use your private health information for the items listed below.

Your individual health information will be used for your treatment. For instance; laboratory testing results and examination finding will be used for reaching a diagnosis.

We will also use this information for billing and collection payments on your account. From time to time, it will be necessary for us to contact your insurance carrier regarding payment and may need to provide your carrier with details regarding your health.

Finally, your health information will be used for health care operations. It may be necessary for us to disclose your information to evaluate the quality of your care and if your treatment proved effective, or to help us conduct cost-management and business planning activities for our practice.

Our staff members are trained to maintain your confidentiality during your visits to our practice, however, by federal and state law we are obligated to disclose your provided information for certain reasons, without your consent. Those reasons may be for public health risks, lawsuit proceedings, law enforcement request, identification of deceased patients, research, organ donation, military requests, or serious threats to our nation's health or security.

You have the following rights regarding your personal health care information

a. The right for confidential communications, i.e. may we leave messages pertaining to your health with other family members or an answering machine?
b. The right to inspect and copy any or all of your information, however, your request must be done in writing and a fee may be charged.
c. The right to paper copy of this notice.
d. The right to file a complaint if you believe your privacy rights have been violated.
e. The right to provide us with an amendment to your authorization at any time, if you have authorized us usage of your health information for reasons other than treatment, payment or health care options.

We will continue to evaluate our efforts to protect your personal information and make every effort to keep your personal information accurate and up to date. If at any time we modify this notice, we will provide you with advance notice of the changes and allow you the opportunity to opt out of such disclosure.

If you have any questions regarding this notice or our health privacy policies, please speak to any member of our health care team. Thank you.

PAYMENT OPTIONS

YOUR PAYMENT OPTIONS

We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time treatment is provided.

PAYMENT- You may make any payment using cash, check, AMEX, Master Card, VISA, or Discover.

IF YOU HAVE COMMERCIAL INSURANCE, we will submit your form to your insurance carrier for you. You are responsible for any deductible or co-payment not covered by insurance. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed, or you may fill out a voucher and have the amount applied to your credit card account. If there is a payment credit, a check will be issued to you within 30 days.

MEDICARE PATIENTS: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount. If you have co-insurance to cover the 20%, we will submit this insurance for payment and you will not have to pay the 20%, just the deductible.

INSURANCE PATIENTS - PLEASE READ CAREFULLY: The percentage of coverage by your insurance company may be based on ***your insurance company's own reduced fee schedule for medical services*** and may be less than actual charges resulting in lower coverage for you. We have no control over this situation. ***Lower payment is a direct result of the plan selected by your employer. Please be advised that WE CANNOT WAIVE CO-PAYMENT. We are required by LAW TO COLLECT CO-PAYMENT.***