



Patient Questionnaire and Release Forms

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Cell Phone \_\_\_\_\_ Social Security# \_\_\_\_\_
Home Phone \_\_\_\_\_ Email Address \_\_\_\_\_
Work Phone \_\_\_\_\_

Marital Status Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Emergency Contact \_\_\_\_\_ Relation to patient \_\_\_\_\_
Phone Numbers \_\_\_\_\_

Family Physician/Internist: \_\_\_\_\_
Phone: \_\_\_\_\_
Preferred Pharmacy \_\_\_\_\_
Phone: \_\_\_\_\_

Insurance Information

Primary Insurance Company Name: \_\_\_\_\_
Insurance Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_
Insurance Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Responsible Party (if other than patient): \_\_\_\_\_
Responsible Party's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you have an HMO insurance? Y [ ] N [ ]

\*\*If yes, you must have your referral or your appointment will need to be rescheduled.\*\*

I authorize Dr. Jennifer Somers/ Somers Foot & Ankle, LLC to release any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to be made to this practice for services rendered. I agree to pay all of my copays, coinsurance, deductibles, and any balance that is denied or in dispute by my insurance company.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_
Patient, parent, or responsible party



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MEDICAL HISTORY

Anemia Y  N

Arthritis (osteo) Y  N

Asthma Y  N

Blood clots Y  N

Blood Transfusion Y  N

Cancer Y  N

Congestive Heart Failure (CHF) Y  N

Cholesterol Y  N

Diabetes Y  N

Emphysema Y  N

Epilepsy Y  N

Fibromyalgia Y  N

Foot/Skin Ulcers Y  N

Gall bladder problems Y  N

High Blood Pressure Y  N

Head Injury Y  N

Hearing Loss Y  N

Heart Attack Y  N

Heart Catheterization Y  N

Heart Problems Y  N

Hepatitis A / B / C Y  N

Hernia Y  N

Kidney Problems Y  N

Liver Disease Y  N

Meningitis Y  N

Migraines Y  N

Multiple Sclerosis Y  N

Paralysis Y  N

Polio Y  N

Rheumatoid Arthritis Y  N

Scoliosis Y  N

Seizures Y  N

Stomach/Intestinal Ulcer or Bleeding Y  N

Stroke Y  N

Tuberculosis Y  N

Thyroid Problem Y  N

Weakness Y  N

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE? (Please list) \_\_\_\_\_

ALLERGIES:

Do you have any allergies to any medications? Y  N

If Yes, Please List \_\_\_\_\_

Do you have any allergies to adhesives? Y  N

If Yes, Please List \_\_\_\_\_

Any allergies to Betadine/iodine/shellfish? Y  N

If Yes, Please List \_\_\_\_\_

Any other allergies not listed? \_\_\_\_\_

SURGICAL HISTORY:

Please list the type of surgery and approximate year of your surgery/surgeries: \_\_\_\_\_

\_\_\_\_\_

MEDICATIONS:

Please list your medications and dosage (or provide a list) , including OTC & herbal, etc.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**SOCIAL HISTORY**

Is there any chance that you could be pregnant? Y  N

If female, date of last menstrual period? \_\_\_\_\_

Do you smoke? Y  N  If yes, how much? \_\_\_\_\_ How Long? \_\_\_\_\_

Have you quit smoking? Y  N  If yes, when? \_\_\_\_\_

Do you drink alcohol? Y  N  If yes, how much? \_\_\_\_\_ How Often? \_\_\_\_\_

Use recreational drugs? Y  N  If yes, what type? \_\_\_\_\_

Do you use any assisted devices? Cane  Walker  Wheelchair  Crutches

Are you currently working? Y  N  Occupation \_\_\_\_\_

If "no" above, please explain why \_\_\_\_\_

Your height? \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight: \_\_\_\_\_ Lbs. Shoe size? \_\_\_\_\_

***FAMILY History: (please CHECK any condition(s) that your immediate family (grandparents, mother, father, siblings, children) suffer(ed) from and their relationship to you:***

Blood clots Relationship to you? \_\_\_\_\_

Blood disorder Relationship to you? \_\_\_\_\_

Cancer / What Type? \_\_\_\_\_ Relationship to you? \_\_\_\_\_

Diabetes Relationship to you? \_\_\_\_\_

Heart disease Relationship to you? \_\_\_\_\_

**CHIEF COMPLAINT:** what is the reason that prompted you to make this appointment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this problem/symptom(s) been present? \_\_\_\_\_

Have you tried or received any prior treatment for this condition? Y  N

If "yes" please explain: \_\_\_\_\_

Patient name printed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_



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PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Do you now or have you recently had any problems related to the following systems? Mark Y or N
If you mark YES to any of the following, please indicate next to that problem the doctor that is treating you.
If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Cardiovascular

Chest pain (recent) Y [ ] N [ ]
Irregular heartbeat Y [ ] N [ ]
Large varicose veins Y [ ] N [ ]
Other: \_\_\_\_\_

Hematological/Lymphatic

Swollen glands Y [ ] N [ ]
Blood clotting problem Y [ ] N [ ]
Other: \_\_\_\_\_

Constitutional Systems

Fever Y [ ] N [ ]
Chills Y [ ] N [ ]
Excessive fatigue Y [ ] N [ ]
Other: \_\_\_\_\_

Gastrointestinal

Abdominal pain Y [ ] N [ ]
Heartburn Y [ ] N [ ]
Vomiting Y [ ] N [ ]
Other: \_\_\_\_\_

Musculoskeletal

Neck pain Y [ ] N [ ]
Hip pain Y [ ] N [ ]
Back pain Y [ ] N [ ]
Knee pain Y [ ] N [ ]
Shoulder/elbow/hand pain Y [ ] N [ ]
Other: \_\_\_\_\_

Integumentary

Skin rash Y [ ] N [ ]
Boils Y [ ] N [ ]
Persistent skin itch Y [ ] N [ ]
Other: \_\_\_\_\_

Ear/Nose/Throat/Mouth

Ear problems Y [ ] N [ ]
Hearing loss Y [ ] N [ ]
Sinus problem Y [ ] N [ ]
Other: \_\_\_\_\_

Neurological

Seizures Y [ ] N [ ]
Tremors Y [ ] N [ ]
Paralysis Y [ ] N [ ]
Numbness/Tingling Y [ ] N [ ]
Other: \_\_\_\_\_

Endocrine

Excessive thirst Y [ ] N [ ]
Tired/sluggish Y [ ] N [ ]
Other: \_\_\_\_\_

Psychological

Do you suffer from depression? Y [ ] N [ ]
Feel severely anxious or nervous? Y [ ] N [ ]

Genitourinary

Urine retention Y [ ] N [ ]
Painful urination Y [ ] N [ ]
Other: \_\_\_\_\_

Respiratory

Wheezing Y [ ] N [ ]
Frequent cough Y [ ] N [ ]
Frequent shortness of breath Y [ ] N [ ]
Other: \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_



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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1 Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Patient Name (printed) \_\_\_\_\_ Date: \_\_\_\_\_ Patient/Guardian Signature \_\_\_\_\_

2 Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Name (printed) \_\_\_\_\_ Phone Number \_\_\_\_\_

Name (printed) \_\_\_\_\_ Phone Number \_\_\_\_\_

Name (printed) \_\_\_\_\_ Phone Number \_\_\_\_\_

3 Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 154.522(b), I hereby request that Practice make all communications to me by the alternative means that I have listed below.

Home telephone number \_\_\_\_\_

Okay to leave message with detailed information

Okay to leave message with call back numbers only

Work telephone number \_\_\_\_\_

Okay to leave message with detailed information

Okay to leave message with call back numbers only

Mobile telephone number \_\_\_\_\_

Okay to leave message with detailed information

Okay to leave message with call back numbers only

Email address \_\_\_\_\_

Okay to leave message with detailed information

Okay to leave message with call back numbers only

Other Instructions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Name (printed) \_\_\_\_\_ Date: \_\_\_\_\_ Patient/Guardian Signature \_\_\_\_\_

Witness Name if applicable (printed) \_\_\_\_\_ Date: \_\_\_\_\_ Witness Signature \_\_\_\_\_



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**Financial Policy for Somers Foot & Ankle, LLC - 2022**

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

**Please initial each line indicating your understanding of our policies:**

\_\_\_\_\_ **COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

\_\_\_\_\_ **DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a \$125 deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

\_\_\_\_\_ **SELF-PAY:** (for non-covered products and services and for patients without insurance coverage): Full payment is due at time of service. A down-payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

\_\_\_\_\_ **REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

\_\_\_\_\_ **NO SHOW:** (failure to present for your appointment): 24 hours-notice is required for cancellation of your appointment and failure to do so will incur a \$50 fee. Failure to provide 24 hours-notice for a scheduled office procedure will incur a \$100 fee.

\_\_\_\_\_ **SURGERY CANCELLATION:** Failure to provide 5 business-days' notice before surgery will incur a \$500 fee.

\_\_\_\_\_ **BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a \$10 re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a \$35 administrative fee will be applied.

\_\_\_\_\_ **RETURN CHECK FEE:** A \$25 fee will be assessed for all returned checks

\_\_\_\_\_ **FMLA/DISABILITY/MEDICAL RECORDS:** There is a \$25 charge for having the doctor complete these forms. Requested forms will be completed within 3-5 business days of diagnosis and care plan. There is a \$20 fee to obtain a copy of your medical records.

**I have read and understand these financial policies.**

\_\_\_\_\_ *Patient Name (printed)*

\_\_\_\_\_ *Date of Birth:*

\_\_\_\_\_ *Patient/Guardian Signature*

\_\_\_\_\_ *Date:*



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Do I need a test for PAD?

Dear Patient,

We want to make sure you are aware of a condition that may affect you. As many as 12 million Americans have Peripheral Arterial Disease (PAD) and many go dangerously unrecognized. It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed due to the buildup of plaque. This is the same disease process that causes blockages of the heart

Poor Circulation may result in the legs when the blood flow becomes sluggish or even blocked. It can result in leg pain or "fatigue", which can limit your physical activity. Having PAD may also increase your risk of heart attack or stroke if untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would like more information please do not hesitate to ask.

Do you have a history of or taken medication for any of the following?

Diabetes

Smoking

High Blood Pressure

High Cholesterol

Do you have any discomfort or aching in your legs when you walk that is relieved by rest? Y  N

Do your legs ever feel fatigued or heavy when walking or are active? Y  N

Do you experience any pain at rest in your lower leg(s) of feet? Y  N

Do you ever need to stop and rest when walking or have difficulty keeping up with others? Y  N

Have you noticed any changes in the color or temperature of your feet? Y  N

Have you experienced poor healing of wounds, cuts or ulcers on your feet? Y  N

\_\_\_\_\_  
*Patient Name (printed)*

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date:*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date:*

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_