**DR. MARK D NELLERMOE, DPM**- **PATIENT HISTORY INFORMATION (PLEASE PRINT)**



**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: M F

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are You Pregnant?** Y N

**Marital Status:** S M D W

**Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Language: □ English □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer/Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Other than self/spouse)

**Referred by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Doctor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Doctor Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was this due to an auto or work injury? Y or N**

**NAME:** First Middle Last

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

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State** \_\_\_\_\_\_\_\_\_**Zip** \_\_\_\_\_\_\_\_\_\_\_\_

**Primary Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OK to leave message?** Y N

**Secondary Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OK to leave message?** Y N

**Emergency Contact Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Secondary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber ID Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Cust. Svc. Phone No**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber ID Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Cust. Svc. Phone No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY** (list illness/surgery and dates)

**HOSPITALIZATIONS**

**OR**

**PREVIOUS MAJOR SURGERIES?** Y N

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

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**SOCIAL HISTORY**

**ALCOHOL:** Y N **SMOKING:** Y N **EXERCISE:** Y N

Drinks per day \_\_\_\_\_\_\_ Packs per day \_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drinks per week \_\_\_\_\_\_ No. of Years \_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_

Year Stopped \_\_\_\_\_\_ HISTORY OF DRUG USE?

□ Pipe □ Cigar Y N

□ Chew □ Cigarette

Y N

**FAMILY HISTORY**

**HAS ANY RELATIVE HAD THE FOLLOWING?**

□ ARTHRITIS

□ CANCER

TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ HEART DISEASE

□ HYPERTENSION (HIGH BLOOD PRESSURE)

□ DIABETES

TYPE I OR II? \_\_\_\_\_\_\_\_

**DRUG ALLERGIES AND REACTIONS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LATEX ALLERGY? Y N**

**PATIENT PREFERENCES**

**Preferred Pharmacy/Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shoe Size** \_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only**

**BP** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pulse** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Temperature** \_\_\_\_\_\_\_\_

**PLEASE LIST CURRENT MEDICATIONS AND DOSAGE**

**(INCLUDE VITAMINS & HERBAL SUPPLIMENTS)**

**Medication Name: Dosage: Used to Treat:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any additional on the back of form, or attach a list.**

**DRUG ALLERGIES AND REACTIONS:**

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

**LATEX ALLERGY?** Y N

**Briefly describe your foot problems and concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Check all symptoms that you CURRENTLY have:** | | |  |  |
| □ Taking Blood thinner | □ Lightheadedness | □ Sleep Apnea | □ Joint Stiffness | □ Dry Skin |
| □ Easily Fatigued | □ Palpitations | □ Blood in Stool | □ Joint Swelling | □ Elevated blood pressure |
| □ Fever | □ Cough | □ Blood in Urine | □ Low back pain | □ Unusual weight gain/loss |
| □ Malaise | □ Shortness of breath | □ Constipation | □ Dizziness | □ Weakness |
| □ Blurred vision | □ Wheezing | □ Diarrhea | □ Frequent headaches | □ Abnormal bruising |
| □ Dementia | □ Ankle sprains | □ Numbness or tingling | □ Slow healing | □ Chest pain |
| □ Sleep disorder | □ Broken bones | □ Peripheral neuropathy | □ Edema Type \_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Joint pain |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **History of Illnesses:** | |  |  |  |
| □ Congestive heart failure | □ Rheumatoid arthritis | □ Diabetes  Type: \_\_\_\_\_\_\_\_\_\_ | □ GERD/gastric reflux | □ AIDS/HIV |
| □ COPD | □ Gout | □ Muscular dystrophy | □ Ankle sprains | □ Degenerative arthritis |
| □ Heart disease | □ PVD/poor circulation | □ Anxiety | □ Heart murmur | □ Reduced liver function |
| □ Asthma | □ Hepatitis | □ Bleeding disorder | □ Depression | □ High blood pressure |
| □ Sleep apnea | □ Broken bones | □ DVT/Blood clot | □ High cholesterol | □ Sleep disorder |
| □ Bronchitis | □Epilepsy/seizures/fainting | □ Hypothyroid  Type: \_\_\_\_\_\_\_\_ | □ Cancer | □ Fibromyalgia |
| □ Lung problem | □ Stomach ulcers | □ Frequent headaches | □ Migraines | □ Stroke |
| □ Multiple sclerosis | □ Tuberculosis exposure |  |  |  |

**FINANCIAL POLICY**

1. **You are responsible for payment of the services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company and that you are ultimately responsible for any unpaid balance.** We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. When insurance is involved we are contractually obligated to collect copayments, co-insurance, and deductibles, as outlined by your insurance carrier. The deductible is the patient’s responsibility. Payment may be due upon departure after reviewing insurance information. Insurance will be notified thereafter.
2. We accept payment in cash, check, and credit card. There is a $25 fee on returned checks.
3. **Medicare requires a minimum of 60 days between visits for at risk patients’ routine foot/nail care**. Note that your Medicare status may not qualify for routine trimming of nails/calluses. If the diagnosis changes (example: fracture, trauma, infections, and so on) the visit may be billed under the new diagnosis. Any changes outside Medicare guidelines will be the responsibility of the patient.
4. **Be aware that some insurance providers may decline payment for non-covered services or supplies**; (example: post-op shoes, certain ankle braces, insoles, superfeet, heel cups, cast protectors and orthotic devices). You will be notified if immediate payment is necessary upon purchasing any of these items. **All supplies are non-refundable.**
5. **Some insurance providers require prior authorization for office visit (for example: HMO insurance, and so on**). **It is the patient’s responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit on the day of service.**

**Our office sends out monthly statements**. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance on your account. You are responsible for any balance due and coordination of payment with your insurance company. You will be responsible for any attorney or court costs due to collections. Interest will accrue if a balance remains unpaid after 60 days.

**We require notice of cancellations 24 hours in advance**. This allows us to offer the appointment to another patient. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

I have read and understand the above financial conditions and I agree to the requirements as stated.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or parent/guardian)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

My signature confirms that I have been informed of my medical provider’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

I hereby authorize Dr. Mark D. Nellermoe, DPM to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other healthcare operations. My protected information may be released to the following individuals:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this information is not completely filled out, we will not release information to anyone listed above.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Mark D Nellermoe

Photo Release Form

For your consideration, I, the undersigned, hereby give Mark D. Nellermoe, DPM and its agent’s permission to have them photograph myself before the start of each treatment I may receive. It is understood that the use of the photographs is for illustrating a medical procedure and demonstration of benefits. It is also understood that the use of the photographs will in no way reveal patient identity.

I hereby release Dr. Mark D. Nellermoe, DPM and its agents from any and all claims and demands arising out of, or in conjunctions with, the photographs.

I am of legal age. I have read the foregoing fully and understand its contents.

**Patient:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of parent or legal guardian if patient is under 18)

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

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_