Advanced Medical Footcare

Song K. Yu, DPM, AACFAS

First	M.I.	Last		D.O.B.
Street (Apt / Unit #)		City	State	Zip
Home Phone#	Cell #		Work #	
❒ Single ❒ Married ❒ Divorced ❒ Widowed			Sex: ❒M ❒F	Age
Social Security #	E-mail			
Occupation			Employer	
Emergency Contact Name	Phone #		Relationship	
Primary Insurance	Subscriber		Employer	
Secondary Insurance	Subscriber		Employer	
Name	❒ Self ❒ Spouse ❒ Parent ❒ Other			D.O.B.
Primary Care Physician	City		Date Last Seen	Phone
Your Pharmacy	City/Location		Phone	
Referred By				

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to Advance Medical Footcare, LLC as agreed upon at the time of treatment for services rendered. I further agree to be responsible for reasonable fees associated with the cost of collection on my account if not paid in full within 60 days of treatment. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Signature:_____ Date:_____

Please complete backside of form ⇨

Patient History Form

Date:_____ Name:_____ D.O.B._____

Reason for visit: *(If injury, date occurred _____)*

_____

_____

Allergies: *(medication / food / environmental)*

❑ None ❑ Aspirin ❑ Codeine ❑ Penicillin ❑ Sulfa ❑ Metals

❑ Other_____

Current Medications and Dosages: ❑ None

_____

_____

_____

Patient Height _____ Weight _____ Shoe Size _____

Past Medical History

Y N		Y N		Y N	
❑❑	Anemia/Bleeding	❑❑	High Blood Pressure	❑❑	Poor Circulation/Phlebitis
❑❑	Arthritis type _____	❑❑	High Cholesterol	❑❑	Leg/Foot ulcer/Wound
❑❑	Cancer type _____	❑❑	Hepatitis/Liver	❑❑	Thyroid disease
❑❑	Diabetes type _____	❑❑	HIV/AIDS	Other_____	
❑❑	Epilepsy/Seizures	❑❑	Kidney Disease	_____	
❑❑	Gastrointestinal/Stomach ulcer	❑❑	Lung Disease/ Asthma	_____	
❑❑	Gout	❑❑	Stroke	_____	
❑❑	Heart Disease	❑❑	Neurologic/Nerve Disease____		

Past Surgical History (procedure and date) ❑ None

_____

_____

_____

Social History

❑ Occupation_____

❑ Children_____

❑ Pregnant/Nursing_____

Tobacco Use ❑ Past ❑ Current ❑ None

Alcohol Use ❑ Past ❑ Current ❑ None

Drug Abuse _____

Family History

❑ Diabetes

❑ Heart Disease

❑ Foot Disorders

Other_____

_____

_____

Patient Signature _____ Date _____

Advanced Medical Footcare™

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care specialists for podiatry care. We are committed to providing you with the best care possible.

We do participate in many insurance plans, however, your insurance policy is a contract between you and your insurance company. Patients must contact their plans for clarification of their benefits. You are responsible for referrals or authorization to seek care at this office.

Copayments, deductibles and noncovered services are to be paid at the time of service.

Payment for services provided are due at the time of the service.

We accept Cash, Check, Visa, Mastercard, Discover, and debit cards.

Accounts past 45 days due are subject to billing and collection fees.

Appointments changed with less than 24 hours notice and Missed appointments will be charged $35.

Patient Signature:_____ Date: _____