FOOTFIRST

PATIENT INFORMATION

PLEASE PRINT CLEARLY & PROVIDE PHOTO ID

Patient Name _____ **Sex** ☐ M ☐ F
LAST FIRST MIDDLE INITIAL

Birthdate _____ / _____ / _____ **Age** _____ **Social Security No** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Spouse/Responsible Name** _____

Address _____ **City**_____ **State** _____ **Zip Code** _____
+4 Digits after Zip Code

Home Phone _____ **Cell Phone** _____ **Business Phone** _____

Email Address _____

Employer Name _____ **Occupation** _____

Nearest Relative not living with you _____ **Phone** _____

Referred by: ☐ Dr. _____ **Internet:** ☐ Facebook ☐ Google ☐ Instagram ☐ Tik Tok ☐ YouTube
Other: ☐ Location ☐ Podcast/Radio ☐ Referral ☐ TV ☐ Not Listed: _____

INSURANCE INFORMATION

Please note: If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card(s) along with the following information:

Policy Name: _____ **Primary Holder's Name:** _____

Insured's Date of Birth _____ / _____ / _____ **Sex** ☐ M ☐ F **Relationship** ☐ Spouse ☐ Parent ☐ Other

INSURANCE AUTHORIZATION AND ASSIGNMENT

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance company. To avoid late payment fees or finance charges, all unpaid balances must be paid within 30 days. For your convenience we do accept Checks, Cash, American Express, Visa, Mastercard, and Discover. Note: If paying by credit card, you are authorizing Foot First to keep your signature below on file and to charge the credit card you have selected for any co-payments that are due or towards any balances on your account.

I hereby authorize Foot First Podiatry Centers, V.P.C. and/or his/her/its staff to disclose my individually identifiable health information to the insurance carrier(s). Foot First Podiatry will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian &/or Insured Signature _____ **Date** _____

FOOTFIRST

MEDICAL INFORMATION | THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH.

Reason for your visit today: _____

Approximately, how long has it been bothering you? ❑ Days _____ ❑ Weeks _____ ❑ Months _____ ❑ Years _____

How would you rate the intensity, on a pain scale of 1-10, with 10 being the most severe:

- Right Foot: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Left Foot: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How often does your discomfort occur? ❑ Constantly ❑ Frequently ❑ Intermittently

What are your SYMPTOMS? Please mark all that apply.

❑ Bruising ❑ Cracked Skin ❑ Difficulty in walking ❑ Difficulty wearing shoes ❑ Discolored nails

❑ Infection ❑ Itching ❑ Numbness ❑ Pain ❑ Redness

❑ Stiffness ❑ Swelling ❑ Thickened nails

❖ **Other:** _____

Does it travel/radiate to any other part of your body? ❑ No ❑ Yes, If yes please explain: _____

Can you describe the SENSATION? Please mark all that apply.

❑ Aching ❑ Burning ❑ Constricting ❑ Cramping ❑ Dull

❑ Sharp ❑ Shooting ❑ Tingling ❑ Throbbing

❖ **Other:** _____

Did anything cause or contribute to the onset of your condition? ❑ No ❑ Yes, If yes please explain: _____

Have you ever had anything like this before? ❑ No ❑ Yes, If yes please explain: _____

What AGGRAVATES your symptoms? Please mark all that apply.

❑ Any activity or movement ❑ Anything touching it ❑ Bearing weight ❑ Climbing stairs ❑ Driving

❑ Exercise ❑ First steps after rest ❑ Prolonged standing ❑ Rest ❑ Running

❑ Standing in general ❑ Walking ❑ Wearing shoes

❖ **Other:** _____

What TREATMENT(S), if any, have you tried to help relieve your symptoms either PROFESSIONALLY or PERSONALLY? Please mark all that apply.

❑ Antibiotics ❑ Arch Supports ❑ Cortisone Injection(s) ❑ Elevating ❑ Icing

❑ Massaging ❑ Orthotics ❑ Rest ❑ Shoe gear modification ❑ Soaking

❑ Stretching ❑ OTC Medications (i.e. Advil, Ibuprofen, Aspirin) ❑ Physical therapy ❑ Taping

❖ **Other:** _____

Any PAST TREATMENT(S) on your feet / ankles? ❑ No ❑ Yes, if yes please explain: _____

PATIENT / GUARDIAN INITIALS: _____

MEDICAL AND SURGICAL HISTORY

- Do you have **DIABETES**? ❑ No ❑ Yes - If yes, please mark if: ❑ Type 1 Diabetic or ❑ Type 2 Diabetic
  Do you take **Insulin**? ❑ No ❑ Yes - If yes, what kind do you take? _____
- Do you have any history of a **HEART PROBLEM**? ❑ No ❑ Yes - if yes please explain: _____

❍ HISTORY OF SURGICAL PROCEDURE(S) | SERIOUS INJURIES | ILLNESSES	❍ PHYSICIAN	❍ YEAR

Do you have any **ALLERGIES** to the following:

- ❖ **Antibiotics**? ❑ Penicillin ❑ Sulfa ❑ Keflex ❑ Other: _____
- ❖ **Medications**? ❑ Codeine ❑ Morphine ❑ Aspirin ❑ NSAIDS ❑ Other: _____
- ❖ **Other**? ❑ Adhesives ❑ Latex ❑ Tape ❑ Iodine Topical ❑ Other: _____

- Have you had any problems with **LOCAL ANESTHETICS**? ❑ No ❑ Yes - If yes please explain: _____
- If applicable, are you **PREGNANT**? ❑ No ❑ Yes
- If applicable, are you currently **BREASTFEEDING** ? ❑ No ❑ Yes

Please list all **PRESCRIPTION MEDICATIONS** you are currently taking, including **OVER THE COUNTER** (i.e. Advil, Ibuprofen) and what they are used for:

_____

_____

SOCIAL HISTORY

- **Current Weight**: _____ **lbs.**
- **Height**: _____
- **Shoe Size**: _____

❖ **Alcohol Use**? ❑ None ❑ Occasional ❑ Mild/Moderate ❑ Heavy | ✱Amount of alcohol consumed _____ (#) drinks per day / week / month

❖ **Occupation**? ❑ N/A ❑ Employed, *do you*: ___ Sit at job (Sedentary) ___ Walk at job ___ Stand at job ___ Sit, walk & stand at job
❑ Homemaker ❑ Full time student ❑ Retired

❖ **Do you Smoke**? ❑ No ❑ Yes - if yes _____ # Pack(s)/day | ❑ Former Smoker - how long did you smoke? _____ Year quit? _____

❖ **Use of Recreational Drugs**? ❑ Never ❑ No longer use ❑ Current User - If current, what is the frequency: _____ # time (month / week / day)

❖ **Do you Exercise?** ❑ No ❑ Yes - if yes, what type and frequency: _____-__

- **Primary Care Physician:** _____ **Date last seen:** _____ ❑ Unknown

Address: _____ City: _____ State: _____ Zip Code: _____

- **Pharmacy Name:** _____ **Phone #:** _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT / GUARDIAN INITIALS: _____

FAMILY HISTORY...any BLOOD RELATIVES currently, or in the past, been treated for the following:

❑ Bleeding Disorder ❑ Bunions ❑ Circulation Problems in Feet or Legs ❑ Diabetes

❑ Gout ❑ Hammertoes ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol

❑ Neurological Disorders ❑ Osteoporosis ❑ Rheumatoid Arthritis ❑ Stroke ❑ Unknown, ADOPTED

❖ **Other:** _____

**REVIEW OF SYSTEMS	HEALTH REVIEW - PLEASE CHECK ALL THAT APPLY:**	
GENERAL:	❑ Chills ❑ Dizziness ❑ Fatigue ❑ Weight gain ❑ Weight loss
HEENT:	❑ Blurred vision ❑ Changes in vision ❑ Change in hearing ❑ Ringing in ears ❑ Sore throat ❑ Difficulty with swallowing ❑ Sinus problems or infections ❑ Cough ❑ Headaches
GENITOURINARY:	❑ Renal (Kidney) Disease ❑ Frequent Urination ❑ Infection ❑ Prostate Disease ❑ Kidney stones ❑ Unusual urine color ❑ Blood in urine ❑ STD
GASTROINTESTINAL	❑ Constipation ❑ Diarrhea ❑ Gerd ❑ Nausea ❑ Reflux ❑ Hepatitis ❑ Cirrhosis ❑ Pancreatitis ❑ Ulcers ❑ Abdominal pain ❑ Change in appetite ❑ Change in bowel habits ❑ Clay colored stools ❑ Gallstones ❑ Trouble swallowing ❑ Vomiting
RESPIRATORY:	❑ Asthma ❑ Breathing Difficulty ❑ COPD ❑ Lung Disease ❑ Tuberculosis ❑ Sleep Apnea
PSYCHOLOGICAL:	❑ Anxiety ❑ Depression ❑ Memory Loss ❑ Confusion ❑ Chemical Dependency ❑ Other: _____
CARDIOVASCULAR:	❑ Chest Pain ❑ Heart Attack ❑ Shortness of breath ❑ Mitral Valve Prolapse ❑ Pacemaker ❑ Murmur ❑ Stroke ❑ High Cholesterol ❑ High blood pressure
ENDOCRINE:	❑ Diabetes ❑ Thyroid Disease ❑ Hormonal Problems ❑ Gout ❑ Foot Ulcers ❑ Heat intolerance ❑ Cold intolerance ❑ Excessive sweating ❑ Excessive thirst or urination
HEMATOLOGIC - LYMPHATIC:	❑ Poor Circulation ❑ PVD ❑ Leg or Calf Pain ❑ Rest Pain ❑ Vein Problems ❑ Swelling ❑ Varicose Veins ❑ Phlebitis ❑ Leg Ulcers ❑ Blood Clots ❑ DVT ❑ Past Transfusions ❑ Leukemia ❑ Lymphoma ❑ HIV / AIDS ❑ Sickle Cell ❑ Cancer - if yes, what type: _____ ❑ Radiation Treatment
MUSCULOSKELETAL:	❑ Joint Pain ❑ Muscle Tenderness ❑ Stiffness ❑ Weakness ❑ Difficulty Walking ❑ Rheumatoid Arthritis ❑ Osteoarthritis ❑ Joint Replacement ❑ Fibromyalgia ❑ Osteoporosis ❑ Gout
NEUROLOGICAL:	❑ Burning ❑ Tingling ❑ Numbness ❑ Paralysis ❑ Tremors ❑ Cerebral Palsy ❑ Head injury ❑ Multiple Sclerosis
SKIN DISORDER:	❑ Rash ❑ Itching ❑ Gerd ❑ Change in skin color ❑ Change in Hair ❑ Hives ❑ Psoriasis ❑ Non-healing Wounds ❑ Easy Scarring
OTHER, please list:	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Foot First Podiatry Centers, V.P.C. of any changes in medical status.

_____	_____	_____
Patient Name (please print)	**Patient/Guardian Signature**	**Date**

PATIENT / GUARDIAN INITIALS: _____

FOOTFIRST

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I the undersigned hereby authorize Foot First Podiatry Centers, V.P.C., Dr. Keith Sklar, Dr. Nicholas Ruckman, Dr. Samantha Sklar and/or such assistants to render treatment and/or therapy to myself that they deem medically necessary in order to treat the condition(s) I have requested from himself/herself and their staff.

Signature of Patient/Guardian _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to Foot First Podia- try Centers, V.P.C., Dr. Keith D. Sklar, Dr. Nicholas R. Ruckman, and/or Dr. Samantha Sklar all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees.

- I hereby authorize the doctor to release all medical information necessary to process this claim.
- I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies.
- I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
- I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian: _____Date _____

Relationship of Guardian to Minor Child _____

FOOTFIRST

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name _____ **Birthdate** _____ / _____ / _____
LAST FIRST MIDDLE INITIAL

I requested that all communications to me (by telephone, mail or otherwise) by Foot First Podiatry Centers, V.P.C. and / or its staff are handled in the following manner:

For written communications: **Address to:** _____

_____

_____

For oral communications: **Call to:** _____

_____

_____

MAY WE LEAVE A MESSAGE? ☐ **YES** ☐ **NO**

Please list all those that have permission to access your healthcare information (eg. Spouse's name, etc).

_____

_____

If the address provided above is not your home address or is not a street address, please provide us with a street address for the purposes of ensuring payment:

_____

_____

Patient or Guardian Signature _____ **Date** _____

FOR PRACTICE USE ONLY

Practice ☐ Accepts ☐ Denies

Privacy Officer Signature _____ **Date** _____

FOOTFIRST

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature

FOOTFIRST

Physician / Office Staff - Patient Email Communication Consent form

If you wish to communicate to the office using email please read this page, print it, fill in the part at the bottom and mail it or bring it to the office. Once received, your chart will be updated and you can begin communicating to the office via email, under appropriate circumstances.

Physician(s) Information:

Name: Dr. Keith Sklar / Dr. Nicholas Ruckman / Dr. Samantha Sklar

Email: office@footfirst.com

Risks of using email

The physician and the office staff of Foot First Podiatry Centers, V.P.C. offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- The physician uses encryption software as a security mechanism for email communications. The patient: (1) agrees to and will comply with the use of encryption software (2) waives the encryption requirement, with the full understanding that such waiver increases the risk of violation of the patient’s privacy

FOOTFIRST

Conditions of using email

The physician and/or the office staff of Foot First Podiatry Centers, V.P.C. will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician and/or the office staff of Foot First Podiatry Centers, V.P.C.. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.

- The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, health care operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

- Although the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. will endeavor to read and respond promptly to an email from the patient, **the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.**

- Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on the physician's email and for scheduling appointments where warranted.

- If the patient's email requires or invites a response from the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.

- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.

- The patient is responsible for informing the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. of any types of information the patient does not want to be sent by email, in addition to those set out in the bullets above. Such information that the patient does not want communicated over email includes:

  _____

  (The patient can add to or modify this list at any time by notifying the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. in writing)

- The physician and/or the office staff of Foot First Podiatry Centers, V.P.C. are not responsible for information loss due to technical failures.

FOOTFIRST

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's computer.
- Inform the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. of any changes in patient's email address.
- Include in the email: the category of the communication in the email's subject line, for routing purposes (e.g., 'prescription renewal'); and the name of the patient in the body of the email.
- Review the email to make sure it is clear and that all relevant information is provided before sending to the physician and/or the office staff of Foot First Podiatry Centers, V.P.C...
- Inform the physician and/or the office staff of Foot First Podiatry Centers, V.P.C. that the patient received the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords
- Withdraw consent only by email or written communication to the physician and/or the office staff of Foot First Podiatry Centers, V.P.C.
- **Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should call the physician's office for consultation or an appointment, visit the physician's office or proceed to the closest emergency department.**

Patient acknowledgement and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Physician and/or the office staff of Foot First Podiatry Centers, V.P.C. and me, and consent to the conditions outline herein, as well as any other instructions that the Physician and/or the office staff of Foot First Podiatry Centers, V.P.C. may impose to communicate with patients by email. I acknowledge the Physician's and/or the office staff of Foot First Podiatry Centers, V.P.C. right to, upon the provision of written notice; withdraws the option of communicating through email. Any questions I may have had were answered.

Patient name (if family, all persons interested): _____

Patient address: _____

Patient email: _____

Patient signature (if family, all persons interested): _____

Date: _____

Physician / Office Staff
Patient Text Communication Consent Form

Your health care is important to us. To provide you with the best possible care, we occasionally send convenient text messages to our patients about their health care. You are currently set to receive text messages for appointment reminders and information about your health care treatment to the mobile phone number you provided our office, but you will not receive text messages about promotions or other services we offer.

We look forward to providing better and more convenient communications with you via text messaging. Our goal is to provide you with relevant and useful information about your health care. Thank you!

Patient acknowledgement and agreement

I acknowledge that I have read and fully understand this consent form and authorize text messaging communication between the Physician and/or the office staff of Foot First Podiatry Centers, V.P.C. and myself to the mobile phone number I have provided.

I understand that I can opt out at any-time by contacting the office.

Patient Name | Guarantor Name: **Date:**

Signature of Patient | Guarantor:

_____

Cell Phone Number to Receive Text Messages: