Health One
PODIATRY

2808 N. 5th Street Highway
Reading, PA 19605
Phone: (610) 921-8800
Fax: (610) 929-6942

1900 Rittenhouse Square,
Suite C3
Philadelphia, PA 19103
Phone: (215) 735-3668

Dr. Patricia Mcilrath, DPM and Dr. Mallory Eisenman, DPM

PATIENT REGISTRATION & HISTORY

PATIENT INFORMATION

Name_____Date_____
Address _____
_____
City _____State _____ Zip _____
Sex M F Single Married Sepated Divorced
Occupation _____ Birthdate _____
Employer _____
Employer's Address _____ Employer's Phone_____
Spouse's Name _____ Birthdate _____ SS# _____
Occupation _____Spouse Employer_____
Whom may we thank for referring you _____

CONTACT INFORMATION

Email _____Home Phone _____Work_____Ext_____
Mobile _____
IN CASE OF EMERGENCY
Name_____ Relationship _____ Phone _____

INSURANCE

Who is responsible for this account_____ Relationship to Patient _____
Insurance Company _____ID# _____Group#_____
Is Patient covered by additional Insurance YES NO
Subscriber Name _____ Birthdate_____ SS#_____
Relationship to Patient _____
Insurance Co._____
ID# _____Group#_____

PATIENT REGISTRATION & HISTORY

MEDICAL HISTORY 1

What is the chief complaint today?

_____

_____

Have you ever been to a Foot Doctor before YES/NO If YES
Name of the doctor _____ Last Visit _____
Do you presently smoke? YES/NO If YES Years Smoked _____
Have you previously smoked? YES/NO I Stopped since _____
Is there a family history of Diabetes? YES/NO

ASSIGNMENT AND RELEASE

I, the undersigned certify that for my dependently have insurance coverage with _____
Dr. _____all Insurance benefits. If any, otherwise payable to use for services reordered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____

Relationship_____Date_____

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits the made all her to me or on my behalf to Dr._____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services, I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If " other health insurance " is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, in signature authorizes releasing of the information to the insurance or agency shown, to medicare assigned cases. The physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

PATIENT REGISTRATION & HISTORY

Medical History 2 (Check all that currently or previously apply to you)

___AIDS/HIV	___Ear Problem	___ Phlebitis
___ Allergies [specify]	___Epilepsy	___ Psychiatric Care
___ Allergies to Medicare or Drugs	___Eye Problem	___Radiation Treatment
___ Anemia	___Fainting/Dizziness	___Respiratory Disease
___ Angina	___Foot or Leg Cramps	___Rheumatic Fever
___Arthritis	___Gout	___Shortness of Breath
___Artificial Heart Valves or Joints	___Headaches	___Sinus Problems
___Asthma	___Hemophilia	___Stroke/ TIA
___Back Problems	___Heart Disease	___Swelling In Ankle, Feet
___Bleeding Disorders	___Hepatitis or Jaundice	___Swollen Neck Glands
___Cancer (specify)	___High Blood pressure	___Thyroid Disease
___Chemical Dependency	___High Cholesterol	___Tired Feet
___Chest Pain	___Kidney Problem	___Tuberculous
___Chronic Diarrhea	___Liver Disease	___Ulcers
___Circulatory Problems	___Low Blood Pressure	___Varicose Veins Venereal Disease
___Diabetes Type I or Type II(circle)	___Nervous Problem	___Weight Loss, unexplained

Please list any other medical condition not list above _____

Family Physician_____ **Last Visit Date**_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years YES/NO

If YES, Please explain _____

Past Surgeries _____

_____

Hospitalization (other than for surgery listed)

MEDICATIONS (include prescriptions, over the counter and vitami ns)

_____

_____

Pharmacy Name(s)_____ **Phone#** _____

_____

Do you take oral contraceptives? YES / NO

ALLERGIES

___**Adhesive / Tape**	___**Demerol**	___**Penicillin**
___ **Anticoagulant Therapy**	___**Iodine**	___**Seafoods**
___**Aspirin**	___**Tocal**	___**Sulfa**

CONSENT

I certify that the above information is true and correct to the best of my knowledge, I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet.

Patient's Signature_____ Date_____

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The Following Charges are in Place

A $25.00 fee will be assessed for any no-shows appointments. Please call to cancel Appointments at least 24 hours prior to your appointment.

A $35.00 fee will be assessed for any returned check for non-payment.

A $25.00 fee will be changed for the completion of insurance and disability forms.

A $10.00 will be assessed if co-payment is not received at time of service. Please bring your co-payment for your visits.

The fee for outstanding accounts that require the assistance of a collection agency, patients will be responsible for the collection agency's service charge. When an account is sent to the collection agency, Health One Podiatry will no longer provide non-emergent pediatric care to the patient until payment is made.

For patient records, we will provide the patient a copy of their medical record up to 1 year at no cost. Anything beyond 1 year of medical record, there will be a charge per page.

_____ _____

Patient Signature **Date**

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COVID 19 PATIENT SCREENING QUESTIONNAIRE

PATIENT NAME _____DATE_____

PLEASE ANSWER THE FOLLOWING QUESTION:

1. IN THE PAST 14 DAYS HAVE YOU OR ANY IMMEDIATE FAMILY MEMBERS TRAVELED INTERNATIONALLY? YES / NO
2. IN THE PAST 21 DAYS HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER KNOWINGLY HAD CONTACT WITH ANYONE WHO TESTED POSITIVE FOR COVID 19? YES / NO
3. IN THE PAST 14 DAY HAVE YOU HAD ANY FLU LIKE SYMPTOMS(FOR EXAMPLE- FEVER, COUGH, SHORTNESS OF BREATH, RESPIRATORY ILLNESS) OR A COLD? YES / NO

POR FAVOR, CONTESTE A LAS SIGUIENTES PREGUNTAS:

1. **EN LOS ÚLTIMOS 14 DÍAS, HA VIAJADO USTED O CUALQUIER MIEMBRO DE LA FAMILIA INMEDIATA? SI / NO**
2. **EN LOS ÚLTIMOS 21 DÍAS, USTED O CUALQUIER MIEMBRO DE LA FAMILIA INMEDIATA TENÍA CONTACTO CON ALGUIEN QUE HAYA PROBADO POSITIVO PARA COVID- 19 ? YES / NO**
3. **EN LOS ULTIMOS 14 DIAS, HA TENIDO ALGUN SINTOMA DELA GRIPE (FOR EM**

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Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we will disclose your health information without your written authorization:

1. To family members or close friends who are involved in your health care;
2. For certain limited research purposes;
3. For purposes of public health and safety;
4. To government agencies for purposes of their audits, investigations and other oversights activities;
5. To authorities to prevent child abuse or domestic violence;
6. To the FDA to report product deficits or incidents;
7. To Law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
8. When required by courts orders, warrants, subpoenas and as otherwise required by law