Soldano Foot and Ankle Podiatry
1540 Ellicott Creek Road, Suite #1, Tonawanda, NY 14150

New Patient Intake Form

Phone: (716) 695-2244 Fax: (716) 695-1073

Welcome. Please complete this packet before your first visit.

PATIENT INFORMATION

Appointment date and time _____

Date of birth _____

Name _____

Address _____

Phone number _____

Phone type ☐ Home ☐ Cell ☐ Work

Email address _____

Preferred method of contact _____

Sex _____ **Race** _____ **Ethnicity** _____ **Language** _____

Emergency contact name and phone _____

Primary care doctor _____

Pharmacy name and location _____

Who referred us to you? _____

INSURANCE INFORMATION

Primary insurance company name

_____

Insured name _____ **Date of birth** _____

Member/subscriber ID number

_____

Secondary insurance company name

_____

Insured name _____ **Date of birth** _____

Member/subscriber ID number

_____

MEDICAL HISTORY

Medications

_____

_____

_____

_____

MEDICAL HISTORY CONTINUED

Allergies

_____

_____

_____

Current medical problems

_____

_____

_____

Surgical history

_____

_____

_____

_____

FAMILY HISTORY

Family history

SOCIAL HISTORY

Marital status	☐ Single	☐ Married	☐ Partnered	☐ Divorced	☐ Widowed
Alcohol use	☐ Never	☐ Rare	☐ Occasional	☐ Daily	☐ History of abuse
Tobacco use	☐ Never	☐ Rare	☐ Occasional	☐ Daily	

LIFESTYLE AND WORK

Drug use ☐ Never ☐ Rare ☐ Occasional ☐ Daily ☐ History of abuse

Exercise ☐ Never ☐ Rare ☐ Occasional ☐ Daily

Employer _____

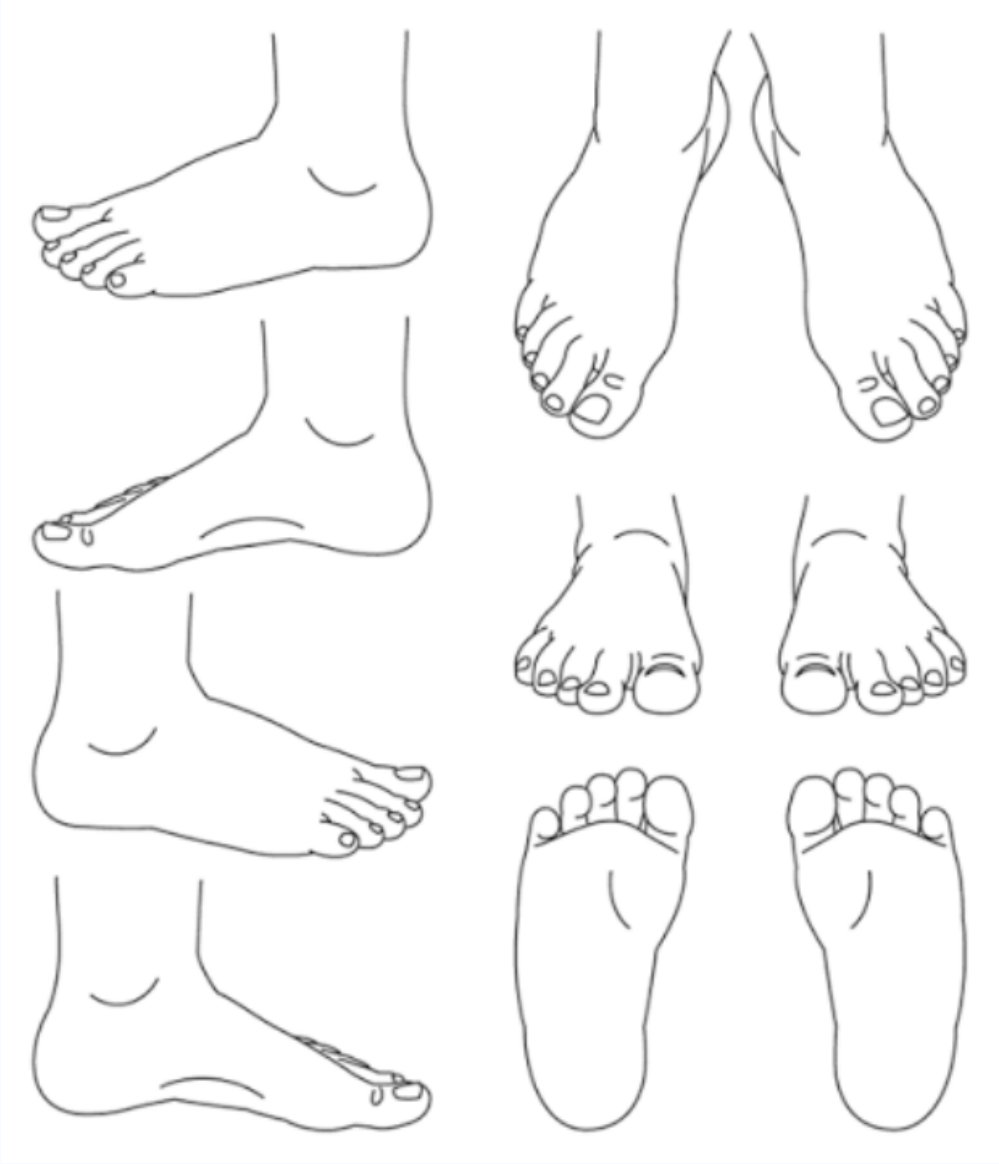
Occupation _____

On your feet at work ☐ 25% ☐ 50% ☐ 75% ☐ 100%

CURRENT FOOT/ANKLE PROBLEM

What specific problem are you currently having?

Where is the pain/problem located? Please mark the pictures below.



PROBLEM DETAILS

How long ago did the problem first start?

_____

How would you describe the pain?

_____

How would you rate the pain from 0 (no pain) to 10 (worst pain possible)?

_____

Does anything make the problem worse?

_____

Does anything make the problem better?

_____

Have you had treatment for this in the past?

_____

Was this caused by a work related injury?

_____

PATIENT CONFIRMATION

To the best of my knowledge, I have answered all the questions on this form accurately. I understand that providing inaccurate information can be dangerous to my health and may affect the treatment plan. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Patient name or parent/guardian _____

Relationship to patient _____

Signature _____ **Date** _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you obtain your maximum allowable benefits. We participate with Medicare, Highmark Blue Cross Blue Shield and their HMO products, Empire, United Health Care and their HMO products, Aetna, Independent Health, Univera, Tricare, and Champ VA. This means we will file your health claim directly with your insurance company. Covered services are subject to deductibles and copays. Copays and/or our deductible fee of $85 is due at the time of service.

For patients that have no health insurance or have an insurance we do not accept, cash pay is an option. We charge $135 for the initial visit and then $100 for any appointments thereafter. All cash pay services must be paid for prior to the services being rendered. We accept cash, check, Visa, Mastercard, Discover, American Express, or any contactless payment methods.

We realize that temporary financial problems may affect timely payment. If these problems arise, we encourage you to contact us as soon as possible for assistance. If you have any questions about the information provided, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help.

Patient name _____

Patient signature _____ **Date** _____

AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information needed to process this claim. I also authorize payment of medical benefits to Dr. Spenser A. Soldano, DPM for services provided to me.

Patient signature _____ **Date** _____

MEDICATION VERIFICATION AND TREATMENT PERMISSION

I hereby give permission to Dr. Spenser A. Soldano, DPM to verify my medications, and administer treatment as may be necessary in the diagnosis and/or treatment of my foot condition.

Patient signature _____ **Date** _____

HIPAA AUTHORIZATION

I authorize Dr. Spenser A. Soldano, DPM to obtain my medical records, consultation reports, diagnostic studies, and treatment records from other healthcare providers as needed for my care. I understand that I may revoke this authorization in writing at any time.

Patient name _____

Patient signature _____ **Date** _____