PENINSULA PODIATRY
SARAH NEITZEL, DPM

NEW PATIENT MEDICAL INTAKE FORM

PATIENT INFORMATION:

Name:_____ Birthdate: ___/___/_____ Male ☐ Female ☐
Preferred Gender Pronoun: (Please Circle)☐He/Him☐She/Her☐They/Them
Social Security Number _____ Marital Status: Single ☐ Married ☐ Other ☐
Home Address:_____
Street **City** **State** **Zip**
PRIMARY Phone (_____) _____-_____ EMAIL: _____

Emergency Contact _____Relationship _____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Other (_____) _____-_____

PRIMARY CARE DOCTOR: _____CITY:_____
OTHER PHYSICIANS: _____CITY:_____
OTHER PHYSICIANS:_____ CITY:_____
Primary Insurance Company Name _____
Secondary Insurance Company Name _____
Please provide cards to the receptionist so we may copy them to your patient chart.

INSURANCE SUBSCRIBER: Name _____DOB ____/____/_____
Relation to Patient _____ Phone (_____) _____-_____

PHARMACY INFORMATION:

_____
NAME OF PHARMACY CITY/ZIP CODE

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Peninsula Podiatry and Sarah Neitzel DPM PLLC. I understand that I am financially responsible for all charges if not paid by insurance. I authorize the use of my signature on all insurance submissions. Peninsula Podiatry and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. I consent to my health information being discussed with other physicians on my medical team. This consent will end when I have submitted in writing a request to end consent.

Please CHECK where we may leave a message if necessary:
☐ Home ☐ Work ☐ Cell

How would you like us to remind you of appointments? ☐ Phone ☐ Email

May we discuss your medical condition with anyone besides you? YES☐ NO☐
If YES, please list the name of that person and their relationship to the patient.
NAME: _____Relationship:_____
PHONE NUMBER: (_____) _____-_____

Patient Name (Print):_____

Patient Signature: _____Date: _____

How did you hear about us? Online Search_____ Facebook_____ Dr. Referral_____ Friend_____
Name of Referral, if applicable, so we may thank them_____

Initial: _____

PENINSULA PODIATRY
SARAH NEITZEL, DPM

NEW PATIENT MEDICAL INTAKE FORM

Medical History *Weight:_____ Height:____*

What is your primary foot/ankle complaint today?

_____
_____
_____
_____
_____
_____

Do you get cramping in your calves after walking? _____
If so, how long can you walk before you have to rest? _____
_____

Do you have pain in your foot/feet? _____
What relieves your pain? _____
What exacerbates the pain? _____
What treatments have you tried? _____
_____

Do you have shoe inserts/orthotics? _____
What activities are you involved in?
_____
_____

Past Family and Social History

Family History: Please check and list family relation:

☐ Diabetes: _____
☐ Cancer:_____
☐ Heart Attack:_____
☐ Stroke: _____
☐ High Blood Pressure: _____
Any abnormal bleeding/slow healing? _____
Do you smoke tobacco? Yes ☐ No ☐
If so, how much (per day/week/etc.)?_____
If you quit, what year?_____
Do you drink Alcohol?_____
If so, what and how often?_____
Do you use recreational drugs? _____

Allergies:

☐ No known drug allergies OR list all allergies below:
_____
_____
_____
_____

Patient Medical History:

☐ Heart Attack
☐ Vascular Disease
☐ Asthma
☐ Liver Disease
☐ Hepatitis
☐ Osteoporosis
☐ Epilepsy
☐ Depression
☐ Congestive Heart Failure
☐ Stroke
☐ Heart Disease
☐ Lung Disease
☐ Kidney Disease
☐ Tuberculosis
☐ Arthritis
☐ Nerve Disorder
☐ Anxiety
☐ High Blood Pressure
☐ Emphysema
☐ Thyroid Problem
☐ Dialysis
☐ Glaucoma
☐ Gout
☐ Alzheimer's
☐ Stomach Ulcers
☐ Heart Murmur/Afib

☐ Diabetes Are you on Insulin? Yes ☑ No ☑
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Cancer: _____
☐ Other: _____

Surgical History: Procedures and complications:

_____
_____
_____
_____

Are you currently taking any medications?
Please list below with dosage and frequency:
_____
_____
_____
_____
_____
_____
_____
_____

Review of Systems:

General:	☐ Fatigue	☐ Weight Changes	☐ Weakness
Head:	☐ Headaches	☐ Vertigo	☐ Dizziness
Neck:	☐ Stiffness	☐ Pain	☐ Masses
Chest	☐ Cough	☐ Shortness of Breath	☐ Wheezing
Heart:	☐ Chest Pain	☐ Palpitations	☐ Weakness
Abdo:	☐ Vomiting	☐ Appetite Change	
Neuro:	☐ Seizures	☐ Tremors	
Psych:	☐ Depression	☐ Anxiety	

Please list other relevant changes:
_____
_____

Initial: _____

PENINSULA PODIATRY
SARAH NEITZEL, DPM

DISCLOSURES: PLEASE INITIAL EACH BELOW

Billing for Services: Our office bills your insurance in accordance with predetermined fee schedules. It is the patient's responsibility to provide accurate, up to date insurance information so that billing may be done correctly. Once services fees are billed to your primary insurance, remaining costs will be billed to your secondary insurance automatically when applicable. If you have not met your deductible, you may be asked to make a payment to the office at the time of your visit. Any services that are clearly not covered by any insurances will be discussed prior to treatment so an upfront cash price can be agreed upon. All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment, as specified in your insurance contract and mandated by your carrier in our participating provider agreement. A denial of coverage for services by your insurance may require you as the patient working with our billing company, Human Medical Billing, to appeal these types of decisions. If you do not have health insurance, charges for all services/treatments are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment discount may be given to patients without health insurance. Any balances due after insurance determinations will be billed to patients by mail. Patients are welcome to contact Human Medical Billing or Peninsula Podiatry to make payments or set up a payment plan. There is a $25.00 fee assessed for returned checks.

Initial:_____

Referrals/Authorizations: It is the patient's responsibility to obtain all referrals if your insurance requires one. If one is not obtained prior to your appointment, you may be responsible for that appointment cost.

Initial:_____

Missed Appointment Policy: We ask that our patients provide us with 24-hour notice if they will not be making their appointment. Consecutive missed appointments or repeated missed appointments without notice will be assessed at a fee of $30.00 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Initial:_____

Collections: Peninsula Podiatry will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail, or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

Initial:_____

Custom Products: I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, CAM Walkers, Spenco or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

Initial:_____

HIPAA Policy: I have read and understand the HIPPA notice, or I decline reading the HIPPA notice but, am fully aware that it is always available to me in my New Patient folder.

Initial:_____

I understand that Peninsula Podiatry's financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If Peninsula Podiatry has any changes, our office will advise you of this and have you fill out a new form/addendum at that time. I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read all of the above financial disclosures, understand, and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Patient Name (Print): _____ Date: _____

Patient/Guardian Signature: _____

Initial: _____