# AEROFEET PODIATRY CENTER
# JOHN F. SWAIM, DPM

NAME OF YOUR PRIMARY PHYSICIAN:______________________________ LAST SEEN:__________

ARE YOU UNDER HOSPICE CARE?__________________

PREFFERED PHARMACY:_________________________ IN WHICH CITY?_______________________

NAME OF PATIENT:_____________________________________________ DATE:_______________

ADDRESS:____________________________________ CITY:__________________ ZIP:___________

BILLING ADDRESS:_____________________________ CITY:_________________ ZIP:____________
(*If different from above*)

HOME PHONE #_________________ WORK #_______________ MESSAGE #________________

**BIRTH DATE**:_________________ **S.S.#**______________________ CALIF. LIC. _____________
***(Required)*** ***(Required)***

AGE:__________ GENDER: Male Female MARITAL STATUS: Married Single Widowed Divorced Other

**RACE:** AFRICAN AMERICAN/BLACK
AMERICAN INDIAN/ALASKAN NATIVE
ASIAN
CAUCASIAN
NAT. HAWAIIAN/PACIFIC ISLANDER
OTHER RACE
UNKNOWN
DECLINED

**ETHNICITY:** DECLINED
HISPANIC OR LATINO
NOT HISPANIC OR LATINO
UNKNOWN

IN CASE OF AN EMERGENCY CONTACT:_______________________ PHONE:_____________________

WHO REFERRED YOU TO OUR OFFICE?___________________________________________________

## OCCUPATION

SELF/ GUARANTOR:___________________________ EMPLOYER:__________________________

ADDRESS:___________________________________________________ PHONE #________________

## INSURANCE INFORMATION

INSURANCE PRIMARY____________________________SUBSCRIBER NAME______________________
(*OTHER THAN SELF)*

SECONDARY INSURANCE_________________________ SUBSCRIBER NAME_____________________

## <u>IF THE PRIMARY INSURED FOR FIRST OR SECOND INSURANCE IS YOUR SPOUSE:</u>

SPOUSE'S NAME:_________________________________ BIRTHDATE:________________________

SPOUSE'S SS#___________________________________

WHO IS FINANCIALY RESPONSIBLE OTHER THAN INSURANCE COMPANIES/SELF?
_____________________________________________________________________________________

S.S.#____________________________ RELATIONSHIP TO PATIENT:_________________________

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### FINANCIAL POLICY

We gladly will bill Medicare and/or your private insurance for you**.** It is your responsibility to contact your insurance to verify that we're a current provider as this changes periodically. **<u>We are not a MEDI-CAL PROVIDER</u>**. You are responsible for the deductible, coinsurance, and non-covered services.

**YOU HAVE THE RIGHT TO REFUSE TO BE SEEN AT THIS APPOINTMENT, CANCELLING AT NO CHARGE.**

We appreciate payment in full at each visit unless we are billing your insurance for you. In this case, your balance is due immediately following your insurance payment. If your carrier has not paid within a reasonable period of time, following billing, you are than responsible for payment in full. We are happy to discuss a payment/financial agreement plan with you if you feel you are unable to make payment in full. Any payment schedule is subject to a finance charge of 1.5% per month if not paid in full 30 days after shift of responsibility to patient. **A CHARGE OF $35.00 WILL BE ASSESSED TO YOUR ACCOUNT FOR "NO SHOW" MISSED APPOINTMENTS.**

### INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to JOHN F. SWAIM, DPM for any services furnished my by that physician. I understand my signature requests that payment be made and authorizes release of medical information necessary to secure the payment(s). I recognize my financial obligation of any coinsurance of deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

### AERONATURAL/ DR SWAIMS PRODUCTS

ALL AERONATURAL/DR. SWAIMS CREAMS, SALTS AND BALMS ARE OVER THE COUNTER AND **<u>NOT BILLABLE</u>** TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

**<u>BY SIGNING BELOW I CONFIRM THAT I HAVE READ AND AGREE TO ALL AFOREMENTIONED FINANICAL POLICIES</u>**

**SIGNATURE ________________________________________ DATE _____________________**

### 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***) Patient or Authorized Representative ***(if applicable)***

______________________________________________ ___________________________

**SIGNATURE** **DATE**

****** **IF YOUR INSURANCE POLICY DOES NOT COVER YOUR CLAIMS AT 100%** PLEASE LIST A CREDIT CARD/ATM CARD FOR BALANCE PAYMENT IF NOT PAID IN A TIMELY MANNER.

NAME ON CREDIT CARD: ______________________________________________

ACCOUNT NUMBER: __________________________________________________

EXPIRATION DATE: __________________________________________________

SIGNATURE: _______________________________________________________

PATIENT:______________________________________________ DATE:__________________

**SHOE SIZE:**________ **WEIGHT**______ **HEIGHT**_______

**FAMILY PHYSICIAN**: ______________________ **LAST SEEN:** ________________________

____ AGE MALE/FEMALE BLOOD TYPE: ____________

**WHY I NEED TO SEE THE DOCTOR:** ________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

IF DISABLED, REASON FOR DISABILITY:

____________________________________________________________________________

____________________________________________________________________________

**ONSET**: ___Sudden ___Gradual DATE OF INJURY_______________________

**WE ARE NOT A WORKMANS COMP PROVIDER**.

**IF THE REASON YOU ARE SEEKING TREATMENT TODAY IS RELATED TO ANY PENDING OR POTENTIAL LITIGATIONS. YES ☐ NO☐**

**Duration:** X _____ days/weeks/months/years

**Nature:** Superficial/Deep Aching/Burning Sharp/Dull Tingling/Shooting Throbbing/Numbness Pressure Constant/Intermittent Swelling/Redness

OTHER:______________________________________________________________________

____________________________________________________________________________

**Improves with:** Weight Bearing/Non Weight Bearing In/Out of Shoes AM/PM
**Worse with:** Weight Bearing/Non Weight Bearing In/Out of Shoes AM/PM

Previous foot/ankle treatment______________________________________________________

____________________________________________________________________________

**SOCIAL HISTORY:**

Do you use Tobacco Y/N  Packs per day_____years________?
Alcohol Y/N drinks per day_____week________
Coffee/Caffeine Y/N _______cups per day

**Employment/Percentage of daily life:**

sitting______walking_______lifting_______standing_______climbing________retired

**ALLERGIES:**

Allergies:  Penicillin  Sulfa Drugs  Iodine  Seafood  Aspirin  Codeine  Vicodin  Darvocet
Adhesive tape  Local anesthetics  OTHER:
____________________________________________________________

**REACTIONS:**______________________________________________________________________
_________________________________________________________________________________

**CURRENT MEDICATIONS:**

_________________________________________for _____________________________________

_________________________________________for _____________________________________

_________________________________________for _____________________________________

_________________________________________for _____________________________________

_________________________________________for _____________________________________

**REVIEW OF SYSTEMS & FAMILY HISTORY:**

**S** Self, **M** Mother, **F** Father, **GM** Grandmother, **GF** Grandfather,

___Anemia___ bleeding disorders___ Blood clots___ Phlebitis
___Arthritis___ Degenerative___ Rheumatoid___ Gout___ Osteoporosis
___Heart disease___ Blood pressure high /low___ Stroke___ MI___ Vascular disease
___Cancer ____________________________________________________
Type____________________________________________________
___Diabetes ***(if self)*** Insulin dependent Y/N  Medication/Diet  ____ # years
___HIV___ Immunity problems ___History of infection ___ Lupus___ Rheumatic Fever
___Hepatitis A/B/C___ Cirrhosis___ Liver disease ___ Alcoholism ___Lung disease ___Asthma
___Emphysema ___Neurological disorders___ Low back___ cervical ___ Spinal injury/disease
___Psoriasis___ Dermatological disease ___Kidney Disease ___Hormone problems
OTHER:__________________________________________________________________________

**Signature:** **Date:**